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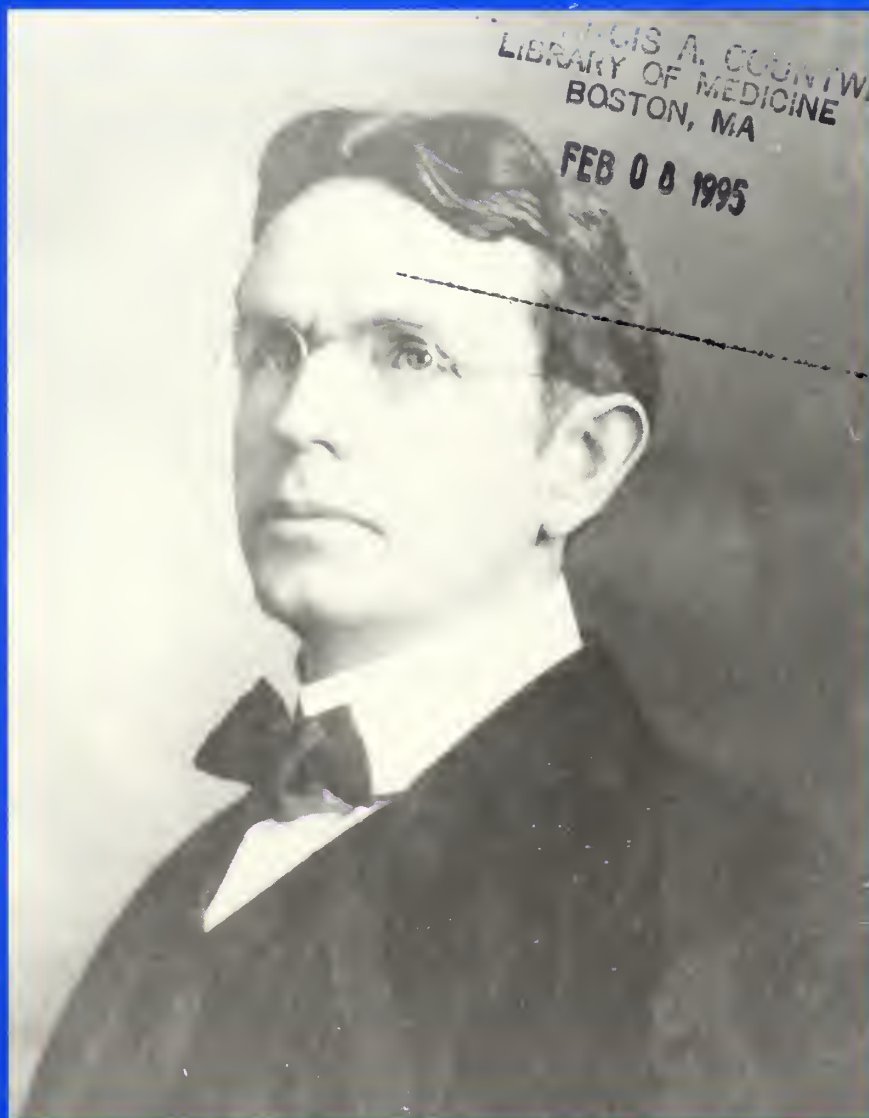


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**CHILD AND ADOLESCENT PSYCHOLOGY
GAMETE AND ZYGOTE INTRAFALLOPIAN
TRANSFER
CHRONIC NAUSEA AND VOMITING
HENRY JEFFERSON STUCKEY, M. D.
THE AMA INTERIM MEETING**

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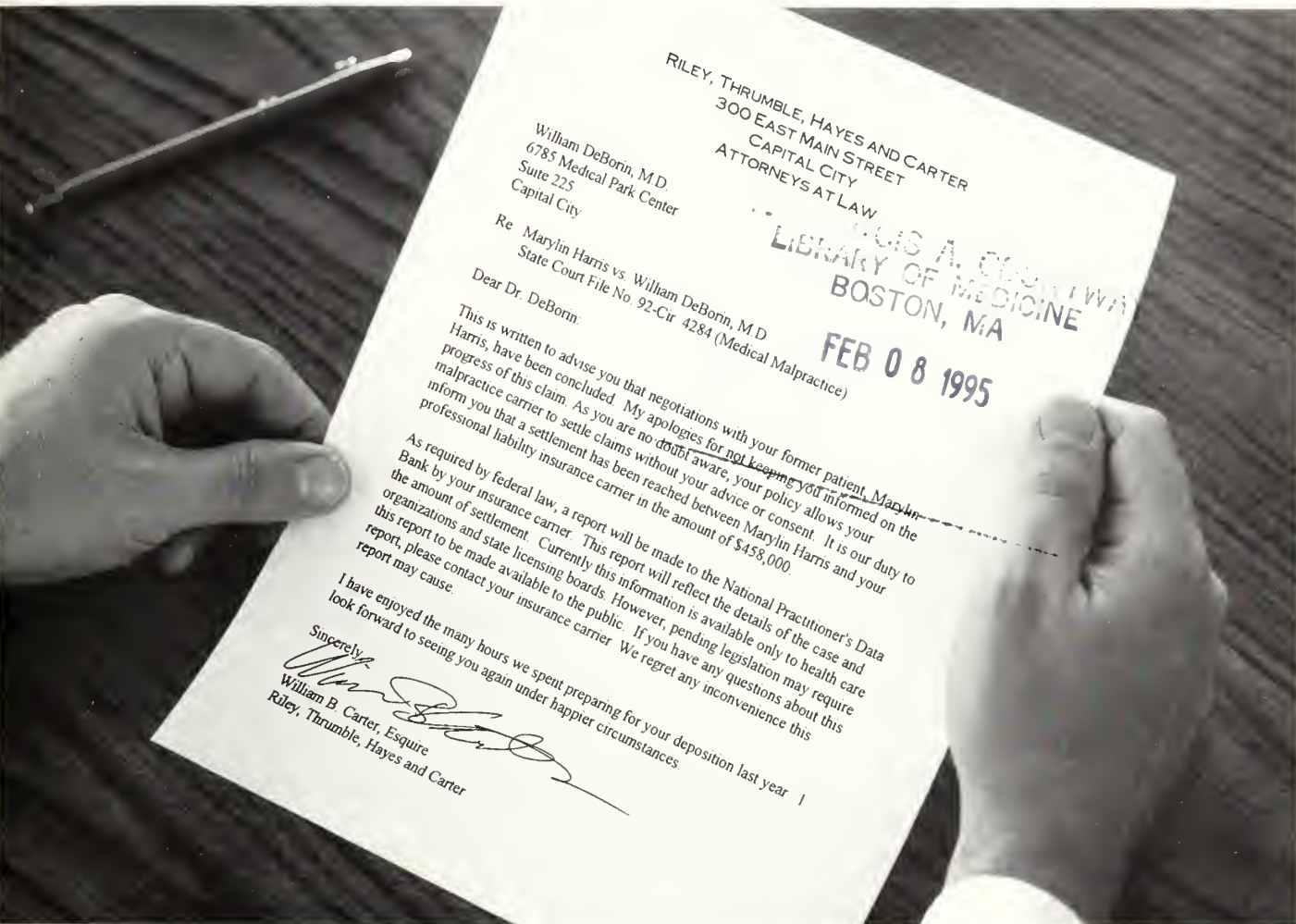
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President's Page

EVERYTHING IS RELATIVE

The Resource Based Relative Value System (RBRVS) was first introduced by the Health Care Financing Administration (HCFA) as a method to bring fairness and equity to the "patchwork and piecemeal" physician fee scale of the Medicare program. Organized medicine (eg. American Medical Association [AMA] etc.) was involved in the process of development and was, in general, supportive of the concept.

In spite of falling into some disfavor, the intent of RBRVS was sound. It brought some "rhyme and reason" to the pricing of medical procedures/services and allowed physicians to make better decisions regarding the adequacy of reimbursement from payors. For patients and their third party reimbursement sources, the value of medical care was easier to discern. In fact the AMA and the SCMA at its 1993 House of Delegates endorsed RBRVS as a valid mechanism for pricing and comparing physician fees.

In early 1992, the South Carolina Workers' Compensation Commission (SCWCC) made known to SCMA staff and the Occupational Medicine Committee (OMC) that it wanted to replace its physician fee schedule with an RBRVS system. The SCWCC at first attempted to remain revenue neutral in the change to RBRVS, and this would have equated to a Conversion Factor (CF) of \$48. SCMA staff analysis showed that this would reduce most existing fees. Through negotiation and compromise (SCMA support for RBRVS conversion in exchange for more equitable rates) a CF of \$52 was agreed upon. This results in an overall increase of 4.1 percent for surgical fees and 5.7 percent for nonsurgical fees.

SCMA has been strongly criticized for the compromise with the Workers' Compensation Commission and yet hindsight does not reveal a better alternative. Stubborn wrangling to maintain the status quo would probably not have been successful and South Carolina doctors would have been faced with across the board rate reductions via a much lower CF instead of the overall eight percent raise they will enjoy.

As the revolution in the health care system proceeds, gains will result from our being proactive and losses from being reactive. Disunity and fragmentation amongst physicians will do further damage. Small groups of specialists who pull away from organized medicine do themselves more harm than good, even though majority opinion (as in this case) means some sacrifices. Those who would benefit from a decline in physician clout and influence are pleased when small groups of doctors go their own way. Remember Dr. Lonnie Bristow's comment at the 1994 Annual meeting, "the strength of the wolf is in the pack." Although everything is relative, staying with organized medicine in these turbulent times will mean more wins than losses.

O. Marion Burton MD

O. Marion Burton, M. D.
President

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CURRENT CHILD AND ADOLESCENT INPATIENT PSYCHIATRIC TREATMENT – EVOLUTION OR REGRESSION?*

DONALD J. CAREK, M. D.**

LISA D. HAND, M. D.

Radical changes in the inpatient psychiatric treatment of children and adolescents in recent years are evident in the psychiatric treatment of children and adolescents at MUH over the past 17 years. These changes reflect both an evolution in the conceptualization of mental disorders and their treatment and the impact of fiscal constraints. This paper will review the evolution of this psychiatric unit and will outline the conceptualization of mental disorders and the principles of treatment that underlie the success of the current short-term treatment program.

When the senior author came to MUH in 1976, it had a 10-bed adolescent unit and an eight-bed child unit with emphasis on long-term (several months to a year or longer) inpatient treatment. In line with conceptualizations at that time, the aim was to "cure" the patient

once and for all, and future deterioration or relapse was viewed as indicative of failure in earlier treatment. The maladaptive behaviors were seen to be rooted in immutable patterns of behavior and intrafamilial interactions that needed to be addressed in extensive individual and family therapies lest the patient revert to his previous maladaptive, pathological state once he left the hospital. There also was a bias against use of medication.

With this approach, the two inpatient units treated a total of approximately 30 patients a year. If in need of inpatient care, the vast majority of children and adolescents were seen as not suitable for such intensive/extensive treatment, but more suitable for some lesser palliative measure, e.g. the State hospital in Columbia.

In 1981, MUH moved toward briefer inpatient stays with emphasis on short-term (30-90 days) treatment for children up to 15 years of age.¹ Philosophy of treatment, not financial constraints, dictated changes in the program, although at that time the sparse literature on short-term inpatient treatment reflected a lack

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of enthusiasm for this mode of treatment. Some interest for such programs was coming alive² but with lingering fear that they would not address the child's psychiatric needs and might become merely repositories for children who were difficult to contain in the community.³

From that humble start, the MUH program slowly evolved into the short-term treatment program currently in existence. When the Department of Psychiatry moved into the Institute of Psychiatry (IOP) in June, 1988, the child and adolescent programs were integrated into one unit of 21 and ultimately 24 inpatients that now are divided into three functional groups based on patient age. The current program stands in dramatic contrast to the original with an average length of stay now of about two weeks and with approximately 500 patients admitted each year.

Financial constraints have pushed the average length of stay down to the 14 day level whereas the authors think that the latitude of 21 days in many instances would be preferable. Almost every child or adolescent patient referred for admission has Medicaid or other third-party payment that will cover short-term hospitalization. The rare patient without any coverage can usually be admitted on Crisis Intervention funds available through the local mental health center with whom we enjoy cooperation in the care of patients.

The short inpatient stay puts the emphasis where it belongs, i.e. working on problems in vivo as much as possible. Separation from family and community is minimized and employed as a means of acute stabilization and regrouping of strengths. It is an opportunity to relieve unbearable tensions, to step back briefly to assess the problems at hand, and to address the acute situation. Those who lament the times when long-term hospitalization held sway tend to forget the short side of those days. One year isolated from their natural environments through psychiatric hospitalization presents many problems, and the fact is that reintegration of these children back into their communities often did not proceed smoothly if at all. There was also a

tendency to restrict contacts with the **family** under the assumption that child and parents needed to work out their problems separately before reuniting them.

The oft-predicted "revolving door" treatment with repeated admissions for any given patient has not materialized. Some are readmitted, even several times. Not only are they in the minority, but on second, third or even fourth admission, the child usually looks to be functioning at a higher level than on his previous admission so that he and the staff are able to capitalize on gains that have been made in previous treatment. It appears that in the inpatient treatment of children and adolescents, as has been true with adult psychiatric patients, the cumulative total length of hospitalization with short-term treatment tends to be shorter than that of one long-term admission.

Comfort with repeated short-term hospitalization has been enhanced by recent, more realistic, views of mental illness. So often those with serious disorders have a chronic condition that is likely to wax and wane over time. Therefore, it is more realistic to think of effective treatment for the moment and development of long-range outpatient treatment that addresses vulnerabilities that may make the patient prone to future decompensations.

The above also goes along with acceptance of relief of symptoms as a legitimate gauge of clinical improvement. With children and adolescents, their symptomatic changes involve diminished disruptive behavior and an increase in more age appropriate behavior. Too often those wedded to models that underlie long-term treatments have been inclined to scoff at emergence of these improved behaviors as a "flight into health" that is likely to crash land. Such conclusions are likely to find their basis in theoretical biases for which there is no clinical evidence. The current approach is not one engendered by abstract philosophical bent but one grounded in clinical experience. Accordingly, the authors have derived some sense of confidence in the evolution of the program which is based on principles derived from current understanding

of mental disorders and their treatment.

Patients come for admission due to an acute crisis or they find themselves in the acute crisis generated by admission. In line with Caplan's conceptualization,⁴ this crisis is a transitional period in which there is a disequilibrium that makes the individual more ready for change and thereby likely to be more responsive to interventions that promote healthful change. If substantial improvement is to occur, this not only is the ideal time, but the only time, ripe for therapeutic interventions. This period of crisis is likely to be a brief interlude in the old maladaptive way that led to admission unless the child and family are introduced into a different, more adaptive, manner of coping with their stresses/problems. One can anticipate that if left to their own devices, they are likely to settle quickly into their old ways of coping. Accordingly, if change is to be effected, the more adaptive means of coping need to be initiated in this early period of hospitalization. If problems in coping persist beyond this point, they are likely to be related to characterological issues, and the child may be a more appropriate candidate for residential treatment that allows for the child to have patterning experiences that promote more mature personality development.

The aim in that brief interlude described above is twofold, mobilization of affect and promotion of more adaptive means of coping. There initially is the mobilization of affect. The child or adolescent who comes for admission frequently manifests a Disruptive Behavior Disorder in which he defends against affect with externalization and maladaptive behaviors. In the process, he remains relatively oblivious of feelings (ordinarily anxiety or depression) because he finds them to be unacceptable. If he cannot experience these emotions, he also is likely to avoid dealing with associated issues as the affect tends to be the gatekeeper to those concerns.⁵ The primary task is to help the patient appreciate that his problem does not rest primarily in the issues that confront him but what he does to avoid

the affect associated with the issues. For example, only after he lifts the mask of anger and the facade of bravado is he able to experience the anxiety and feelings of insecurity and to let himself be supported to address the very real issues, be they developmental or interpersonal, that generate those feelings.

This mobilization of affect is really the first step in any successful therapy geared toward helping the patient become more aware of himself so as to act more reasonably. If the child/adolescent can become tolerant of the painful feelings he has been avoiding, he lays the groundwork to address conflicts in a manner that is more likely to result in behavioral changes.

The primary focus then in hospitalization is not on resolution of conflicts but in helping the child/adolescent to develop greater capacity to address conflict. An illustration of a relatively successful hospital stay is seen in the treatment of eight-year-old John who came to the hospital because of markedly disruptive behavior at school and in his adoptive home. His adoptive parents were at a loss in dealing with him as they felt there was no way of getting him to do what was expected. They questioned whether he ever had bonded with them. John proved to be very much closed emotionally, but he engaged in many interpersonal skirmishes that allowed him to avoid feelings of anxiety and dysphoria. During his 17-day hospital stay, emphasis was on helping him tolerate the emergence of these feelings. His improvement was reflected in his subsequent early outpatient visits. His mother reported that John had for the first time come to their room at night fearful and crying. She really felt elated because she now felt some connection with him and moved to comfort and support him. The diminution of his disruptive behavior also broke down the barriers between them.

The second aim in this time of crisis is the promotion of more adaptive means of coping. Obviously, mobilization of affect to address feelings goes hand in hand with developing more adaptive means of coping. The two are intertwined in the various features of the pro-

gram and both are emphasized intensively during the brief hospitalization. It is the development of a highly structured program that has allowed for effective interventions. The traditional accredited school, occupational therapy and recreation therapy components have narrowed their focus to target specific shared goals for any given patient over the short stay. Each age group of seven to nine patients has a tightly knit nursing team that is under the direction of a masters level nurse in conjunction with the team's attending psychiatrist, social worker, psychologist, and trainees. The key to effective intervention is efficient coordination of the efforts of many highly skilled professionals toward a limited number of realistic goals. The unit prides itself on developing adaptive coping strategies with a "seize each opportunity" philosophy.

What about the use of medication? While ultimate development of more adaptive skills remains the desirable goal, medications offer much in many instances to help the child or adolescent settle down and become more responsive to psychotherapeutic and educational interventions. Stimulants for ADHD aspects of the patient's dysfunction and the tricyclic antidepressants for the anxious and depressed features are frequently employed. The faculty's child psychiatrist-psychopharmacologist-researcher is frequently consulted with complex cases.

Reservations about post-discharge expectations are fueled by disbelief that something other than a superficial assessment can be attained in a short hospital stay. Doubts that the child can maintain change when sent back into his "pathological" environment reflect a focus on only the pathological in families and not the strengths that also are usually present. With emphasis on modeling mature interactions with the patients, caregivers are expected to be active in the treatment process in both family therapy and in unit "on the job training" interventions. In addition, inpatient changes often facilitate change in the other aspects of the family system as well. As in the example cited earlier, more open and

more direct communication often finds reciprocation in more supportive reception.

There is the basic assumption of the program that it is developing and initiating a treatment plan which includes the family and that will be gradually carried through to completion, usually on an outpatient basis. This is held so firmly that outpatient services have been structured with priority given to follow up treatment of inpatients not served elsewhere.

CONCLUSIONS

The authors are confident that the model of inpatient child and adolescent psychiatric treatment described herein is well suited to handle the vast majority of patients in need of hospitalization. The progression from treating 30 patients a year to 500 is seen as a progressive and not regressive move. The MUH program thereby tends to patients its psychiatrists never would have seen 17 years ago and in most instances has demonstrated that child and adolescent psychiatry has much to offer in the management of very difficult children. For the most part, it has also allowed for psychiatric intervention in a less disruptive fashion—in a hospital setting in the patient's community, with the child or adolescent quickly returning home if at all possible or to other placement setting in the community. It also has pressured for emphasis on longer term psychiatric treatment on an outpatient basis with the child and adolescent supported psychiatrically in the natural setting of home, school and community at large, not in prolonged isolation in a hospital setting. □

REFERENCES

1. Moultrie MB, Carek DJ: Short-term inpatient treatment of children and adolescents. *JSC Med Assoc* 79:30-32, 1983.
2. Pfeffer CR: A model for acute psychiatric inpatient treatment of latency-age children. *Hospital and Community Psychiatry* 30:547-551, 1979.
3. Berlin IN: Developmental issues in the psychiatric hospitalization of children. *Am J Psychiatry* 135:1044-1048, 1978.
4. Caplan G: *Principles of Preventive Psychiatry*. New York: Basic Books, 1964.
5. Carek DJ: Affect in psychodynamic psychotherapy. *Am J Psychotherapy* 44:274-282, 1990.

GAMETE AND ZYGOTE INTRAFALLOPIAN TRANSFER

GARY HOLTZ, M. D.*

Initially reported in 1984,¹ gamete intrafallopian transfer (GIFT) more closely mimics the natural events which occur during the establishment of a pregnancy than does in vitro fertilization and embryo transfer (IVF/ET). In general, this procedure produces a greater pregnancy rate and one which is impaired to a lesser degree by advancing female age than is that of IVF/ET.²

As with the latter, ovarian hyperstimulation is achieved with human menopausal gonadotropins (HMG) and monitored on an outpatient basis with vaginal ultrasonography and serum estradiol determinations. Often an LRH analog is employed in conjunction with the stimulation efforts. Oocyte maturation is completed following administration of human chorionic gonadotropin (hCG) and ovum retrieval is performed 32-36 hours later via either a transvaginal ultrasound-directed approach or laparoscopically. Semen processing is performed immediately prior to the retrieval in an effort to concentrate a highly motile fraction which is free of debris, seminal plasma and bacteria. One fallopian tube is usually cannulated via the laparoscope and a predetermined number of ova (three to seven) and sperm (50,000-200,000 progressively motile) are injected into the ampulla. Fertilization therefore occurs at the natural site. Culdoscopic and transcervical cannulation techniques have also been employed. To date, the latter has been reported to produce lower success rates than does laparoscopic cannulation through the distal tubal ostia.

Not infrequently peritoneal adhesions, fimbrial agglutination or endometriosis are treated concurrently; this therapy does not

adversely affect the efficacy of the GIFT procedure. Additional hormonal support (progesterone or hCG) is administered subsequent to the transfer in an effort to increase the opportunity for implantation.

MECHANISMS OF GIFT

GIFT increases the pregnancy rate only during the treatment cycle. Its impact is thought to be due to the increased number of gametes placed within the fallopian tube, possible selection of the best quality gametes, and through insuring that these are transferred to the optimal site for fertilization.

For GIFT or zygote intrafallopian transfer (ZIFT) to be considered, at least one fallopian tube must be reasonably normal in its appearance and patent. It must also be possible to successfully cannulate the tube. A patent fallopian tube which is not mobile due to adhesions, or one with severe convolution, does not allow adequate cannulation via the laparoscope and has generally been a contraindication to intrafallopian deposition of gametes or pre-embryos.

PROGNOSTIC FACTORS

Candidates for GIFT include those with unexplained infertility, endometriosis, failed donor insemination, cervical factor infertility, peritoneal adhesions, male autoimmunity, ovulatory dysfunction and donor oocyte recipients. Also potential candidates are those with mild male factor infertility, those with tubal factor infertility with good prognostic indicators (and an acceptably low risk for ectopic gestation), and couples in which the female is positive for relatively low titers of antisperm antibodies. To a large degree such patients are also candidates for ovarian hyperstimulation/intrauterine insemination (OHS/IUI).

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Success rate, cost, patient age, psychological factors and number of previous failed OHS/IUI cycles all influence decisions as to which treatment modality is appropriate.

In 1991 the average rate of deliveries/retrievals for GIFT procedures performed in the United States was 26.5 percent.² However, numerous factors influence the success rate for GIFT, including diagnosis, number of ova transferred and the woman's (or egg donor's) age. Overall pregnancy rates vary from 50 percent to 20 percent per completed cycle, depending on diagnosis (Table 1). An overall pregnancy rate per completed cycle of 48 percent has been achieved at the Southeastern Fertility Center in patients 36 years of age or younger with a diagnosis of cervical factor, endometriosis, ovulatory dysfunction, failed donor insemination and unexplained infertility. The number of ova transferred also significantly influences the success rate when controlled for patient age and diagnosis. Increased numbers of ova can be utilized to compensate for impaired prognosis without increasing unacceptably the risk of multiple gestation.⁴ As a consequence, we routinely advocate the use of larger numbers of ova when treating patients with male factor infertility, those employing cryopreserved donor sperm, and those of advanced age. Depth of tubal cannulation is also thought to have a marked impact on success rate. Cannulations of <3 cms. depth have been documented to produce a significantly lower pregnancy rate when controlled for other variables.⁵ The use of mature or intermediate stage ova seems to have no significant impact on success. However, the use of immature ova has generally not been effective.

Controversy exists regarding whether or not the opportunity for a successful GIFT procedure is uniform in consecutive attempts. First cycles seem to enjoy a somewhat greater pregnancy rate than do subsequent ones in our experience. It is also unknown whether or not a previous successful cycle is indicative of a superior prognosis for future procedures, although this is probably so. Previous failed

TABLE 1
OVERALL GIFT PREGNANCY RATES
BY DIAGNOSIS*

Ovulatory Dysfunction	48%
Egg Donor Recipient	50%
Endometriosis	44%
Failed Donor Insemination	44%
Cervical Factor	44%
Unexplained Infertility	43%
Peritoneal Adhesions	42%
Tubal Factor	31%
Male Factor	24%
Immunologic	21%
Vasectomy Reversal	0%

*SEFC, November, 1987 to June, 1993, 466 cases.

treatment with OHS/IUI has no impact on the incidence of success with GIFT.⁶

RISKS OF GIFT

The incidence of multiple gestation in pregnancies established with GIFT is increased; most programs report viable multiple gestation rates of <30 percent.² However, it is very much dependent on the number of ova transferred, female age and diagnosis. The ability to control the number of ova utilized can actually reduce the risk of multiple pregnancy for some patients with ovulatory defects who otherwise overstimulate and ovulate excessive numbers of ova. Couples should be counseled regarding the converse risks of failure and multiple gestation, and the impact that variable egg numbers have on these. The risk of ectopic pregnancy is not significantly increased over that in the general population. Clearly, patients with a history of pelvic infection, tubal gestation, and tubal reconstructive surgery have an increased risk; patients with a history of intrauterine DES exposure or anomalous fallopian tubes may be at increased risk. Many authors have considered prior tubal reconstructive surgery or ectopic pregnancy a contraindication to GIFT

because of this; however, the viable pregnancy rate achieved in selected patients may still be equivalent or superior to that generally obtained with IVF/ET. We reported a 23 percent live birth rate/completed cycle in such a group when they had no additional male or immunologic factors present. The clinical ectopic pregnancy rate was 12 percent.⁷ (Approximately 5.5 percent of pregnancies achieved through IVF are extrauterine.²) Moreover, some patients may enjoy significantly better insurance coverage for GIFT than for IVF/ET. The incidence of clinical miscarriage (13 percent) and of biochemical pregnancy (11 percent) in our series of over 450 completed GIFT cycles is typical of that reported, and minimally increased over that in the general population.

ZYGOTE INTRA FalloPIAN TRANSFER

The development of tubal transfer procedures following *in vitro* fertilization, collectively referred to as zygote intrafallopian transfer (ZIFT), arose from the observation that GIFT seemed to provide a higher pregnancy rate than did IVF/ET. The tubal environment may be preferable for gametes and early stage preimplantation embryos; a number of unique growth factors are produced by cells lining the fallopian tube. Additionally, transfer into the fallopian tube may offer a superior opportunity for embryo retention as compared to transcervical transfer into the uterine cavity. ZIFT may be broken down into transfer of pronuclear stage oocytes (PROST), or transfer of cleavage stage embryos (TET).

Indications for ZIFT include the presence of high levels of antisperm antibodies in the female, significant male factor infertility, male autoimmunity, repeated unsuccessful GIFT procedures, and when donor ova are being employed.⁹ In the first situation, donor serum is used in the culture media, substantially reducing the levels of antisperm antibodies that sperm are confronted with. Fertilized oocytes or early preimplantation embryos are also thought less likely to be impaired by sperm antibodies present in the

female reproductive tract. The use of *in vitro* fertilization also permits insemination of large numbers of ova in situations in which impaired rates of fertilization may be anticipated, such as with significant male factor infertility. Similarly, micromanipulation procedures may be performed, enhancing fertilization rates. Excessive numbers of pre-embryos may be frozen for later use, should they be generated. It further allows documentation of whether fertilization occurs, which may be of prognostic importance. The latter can also be accomplished by performing GIFT and utilizing extra ova for IVF. ZIFT may be preferred to GIFT when employing anonymously donated ova as it facilitates keeping the donor and recipient physically separated as egg retrieval and embryo transfer occur on different days. Post-thaw cryopreserved embryos may also be transferred into the fallopian tube. This approach may confer a better chance of implantation than does transfer into the uterine cavity.

Contraindications to, and risks of ZIFT are similar to those of GIFT. Pregnancy and implantation rates for ZIFT are generally reported as less than those for GIFT and superior to those for *in vitro* fertilization with intrauterine embryo transfer.² However, some programs have failed to note the latter disparity. Pregnancy rates are influenced by number and quality of embryos transferred, and by patient (and/or egg donor) age. Diagnosis is of importance only as it impacts fertilization rates. ZIFT is unacceptable to a small number of couples because of religious or moral conflicts with the use of pre-embryos.

TRANSCERVICAL PROCEDURES

A number of programs, including our own, have successfully performed transcervical GIFT and/or ZIFT procedures. Although transcervical transfers can be accomplished utilizing the hysteroscope to aid in cannulation, most such procedures have been performed with tactile or ultrasound controlled passage of the Jansen-Anderson catheter system.¹⁰ The advantages of avoiding an endoscopic or

mini-laparotomy transfer procedure are obvious and include reduced surgical and anesthetic risks, discomfort and cost. It remains to be determined, however, whether or not there will be a substantial reduction in the success rate obtained with transcervical intratubal transfer procedures. Our initial experience is encouraging; no significant difference in embryo implantation rates was noted for ZIFT procedures as performed via transcervical or laparoscopic techniques. Transcervical transfer also allows successful utilization of the fallopian tube in patients who have significant peritoneal adhesions impairing cannulation through the fimbriated end of the tube.

MINIMAL STIMULATION

There is considerable interest in the use of unstimulated or minimally stimulated cycles for IVF. These reduce cost, monitoring demands on the patient and risk of multiple pregnancy, as lesser numbers of ova and therefore embryos are available. An overall pregnancy rate of 36 percent/retrieval has been achieved at the Southeastern Fertility Center when performing minimal stimulation IVF/ET. There may be some potential applications with ZIFT; however, with GIFT it is difficult to compensate for impaired egg maturity, therefore requiring more aggressive stimulation protocols. □

REFERENCES

1. Asch RH, Ellsworth LR, Balmaceda JP, Wong PC. Pregnancy after translaparoscopic gamete intrafallopian transfer. *Lancet* 2:1034, 1984.
2. Assisted reproductive technology in the United States and Canada: 1991 results from the Society of Assisted Reproductive Technology. *Fertil Steril* 59: 956-62, 1993.
3. Jansen RPS, Anderson JC. Transvaginal gamete and embryo transfer to the fallopian tubes. Submitted for publication.
4. Holtz G, Patton, GW Jr. Gamete intrafallopian transfer (GIFT): factors influencing outcome. Presented at the 44th Annual Meeting of the Continental Gynecologic Society, New Orleans, LA, April 5-8, 1992.
5. Yee B, Rosen GF, Chacon RR, Soubra S, Stone SC. Gamete intrafallopian transfer: The effect of the number of eggs used and the depth of gamete placement on pregnancy initiation. *Fertil Steril* 52:639-44, 1989.
6. Robinson D, Syrop CH, Hammitt DG. After superovulation intrauterine insemination fails: the prognosis for treatment by gamete intrafallopian transfer/pronuclear stage transfer. *Fertil Steril* 57:606-12, 1992.
7. Holtz G, Patton GW Jr, Schwartz K. Gamete intrafallopian transfer in patients at increased risk for ectopic pregnancy. Presented at the 46th Annual Meeting of the American Fertility Society, Washington, DC, October 13-18, 1990.
8. Yovich JL, Yovich JM, Edirisinghe WR. The relative chance of pregnancy following tubal or uterine transfer procedures. *Fertil Steril* 49:858-64, 1988.
9. Yovich JL, Blackledge DG, Richardson PA, Matson PL, Turner SR, Draper R. Pregnancies following pronuclear stage tubal transfer. *Fertil Steril* 48: 851-57, 1987.
10. Patton GW Jr, Holtz G, Edwards A, Swartz K. Transvaginal embryo transfer during the ZIFT procedure. Presented at the 56th Annual Meeting of the South Atlantic Association of Obstetricians and Gynecologists, Orlando, FL, January 15-18, 1994.

CHRONIC NAUSEA AND VOMITING: A CASE REPORT

LESA BETHEA, M. D.*

The purpose of this article is to report a case of chronic nausea and vomiting that, on investigation, was found to have an unusual etiology.

CASE REPORT

The patient, a 36-year-old black female, was in her usual state of health until she presented to the Family Practice Center of Richland Memorial Hospital approximately one year and six months prior to admission. Her chief complaint at that time was heaviness in the chest just below the rib cage for several days. She described the pain as a pressure-like sensation without radiation, which occurred at rest, relieved somewhat by ibuprofen (Motrin®). The pain was constant without relation to exertion or meals. She also complained of frequent belching and early satiety. She denied cardiac risk factors including cigarette smoking, hypertension, diabetes or family history of heart disease. Her only medication at that time was penicillin, which she was taking for a recently diagnosed strep pharyngitis. She weighed 138.5 pounds; blood pressure was 110/74. Physical exam at that time was unremarkable. EKG revealed a normal sinus rhythm at a rate of 70. Chest x-ray was normal. The diagnosis was non-cardiac chest pain. She was instructed to take an antacid as needed and follow-up if her symptoms recurred or worsened.

She was next seen in the Richland Memorial Hospital emergency room three months prior to admission with complaints of intermittent nausea and vomiting and not feeling well. The patient also complained of weight loss and slight dizziness. She denied abdominal pain,

fever, vaginal discharge or symptoms of urinary tract infection. Vital signs 98.3; 69; 16; 118/78. Physical exam was unremarkable. White count was 5,600. Her hemoglobin was normal as was an electrolyte panel and urinalysis. A urine pregnancy test was negative. Her diagnosis by the ER physician was mild dehydration, probable gastroesophageal reflux and gastroenteritis. She was given a liter of an electrolyte drink (Gatorade®), which she drank in the ER, and a prescription for ranitidine (Zantac®) 150mg po bid x 2 weeks.

The patient returned to the ER the next day complaining of continued nausea and vomiting. History revealed a 10-11 pound weight loss over one month with decreased appetite. Vitals: 98.2; 98; 18; 110/71. Physical exam was unremarkable. The diagnoses were viral illness, fatigue, and vomiting. She was given promethazine (Phenergan®) 25mg IM and told to continue her other medications.

She was seen four days later in Family Practice with digestive problems for about one month including a lot of belching but no real pain. She denied alcohol or cigarette use, but stated she had been under a lot of stress. Vitals: 90/70; 80; 98.0; weight 129 pounds. Physical exam was normal. Her diagnosis was epigastric discomfort, indigestive type symptoms. She was scheduled for an upper gastrointestinal barium study with small bowel follow through (Upper GI with SBFT), which showed only a few diverticula involving the small bowel without evidence of ulcer disease.

She was seen two weeks later for follow-up, at which time she gave a one-month history of nausea, vomiting, weight loss and diarrhea. She stated the Zantac® she had been placed on helped a little with her symptoms and she had stopped taking the Phenergan® because her

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nausea had resolved. Vitals: 100/62; height: 64.5"; weight 130 lbs. Physical exam was normal; the stool was heme-negative. A SMAC and a CBC were ordered. The SMAC was normal except for a slightly low LDH at 104 u/l. A CBC revealed a white count of 3,500 with a normal differential. Her hemoglobin was 11.4 gm/dl. The rest of the CBC was normal. Stool studies showed rare white blood cells and mixed morphology bacteria. O & P was negative, as was culture for salmonella, shigella, yersinia and campylobacter. A flexible sigmoidoscopy was scheduled. Diagnoses were nausea, vomiting and diarrhea of unclear etiology.

Ten days later a counselor for the Employee Assistance Program at Richland Memorial Hospital spoke with the patient's physician. She stated that she had been seeing the patient because of job difficulties, and wanted to report that the patient had been having some unusual symptoms such as staring into space, losing time and a feeling of wading through water. She was wondering if there might be something physical going on. The physician assured her it would be addressed at the patient's next visit.

The patient was seen the next day with a chief complaint of headaches off and on for a couple of months, associated with vomiting. She denied abdominal pain, but continued to complain of frequent belching. She also complained of increasing fatigue and forgetfulness. She stated her husband had noted a change in her behavior and activity level. She denied a history of mental illness or hallucinations. Vitals: 100/70; 78; 97.9; weight 130 lbs. Neurological exam was normal as was the rest of her exam. Her diagnosis at that time was headaches with vomiting. The comment was made that the history was confusing. The patient was told to keep a record of her headaches and associated symptoms as well as a list of foods. She was to return with her husband for follow-up. Consideration was given to doing an abdominal ultrasound.

The patient was seen nine days later with continued nausea and vomiting. She also was

complaining of problems at work. The patient denied being depressed or having difficulty with sleep. She again complained of weight loss because she was afraid to eat, due to nausea and vomiting. She also again complained of headaches every other day and occasional diarrhea. She denied any blood loss. Vitals: 110/66; 72; 98.4; height 65.5"; weight 130 lbs. (down 8.5 pounds from July, 1992). Her physical exam was remarkable for a flat affect and mild diffuse abdominal tenderness. The diagnosis at that time was chronic nausea of unclear etiology. She was referred to the gastroenterology department, where a colonoscopy and EGD were performed to rule out inflammatory bowel disease because of white cells in the stool. A gastric emptying study was negative, as was an abdominal ultrasound. B₁₂, folate, iron studies and a hemoglobin electrophoresis were done to evaluate her anemia. Thyroid function studies were ordered to rule out hypothyroidism. ANA, RF, SM, RNP, Scleroderma, Sjorgren's, DS DNA and Centromere antibodies were ordered because of a history of possible Raynaud's phenomenon. Her reticulocyte count was low at 0.3, hemoglobin was normal at 12.0 gm/dl, ferritin high at 211 ng/ml, ANA 1:80, RNP > 100, haptoglobin high at 180 mg/dl. All other levels were normal. The assessment of the gastroenterologist was possible gastroesophageal reflux and the patient was placed on omeprazole (Prilosec®). She was referred back to the Family Practice Department for further evaluation of persistent headaches.

The patient was seen the day of admission for continued nausea, vomiting and headaches. A gadolinium-enhanced MRI and CT of head was ordered which revealed a 6 x 6 x 5 inch mass (Figures 1 and 2). The mass was excised the next day by neurosurgery and pathology revealed a fibrous meningioma.

At follow-up approximately one month later, the patient still had intermittent headaches relieved by acetaminophen (Tylenol®). She also complained of some weakness of the left hand. Her exam was

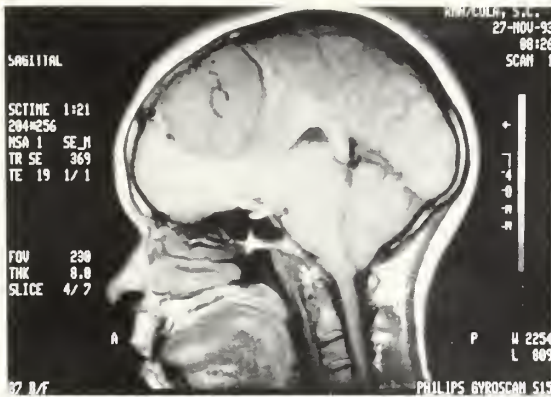


Figure 1. MRI scan showing frontal meningioma.

without neurological abnormalities.

DISCUSSION

This case illustrates the slowly progressive nature and subtle psychological personality changes that can be associated with frontal meningiomas. In addition, the differential diagnosis of chronic nausea and vomiting should include frontal meningioma. The meningioma is a benign tumor of arachnoidal tissue. It grows very slowly and may produce symptoms for several years. Meningiomas have several characteristic sites of origin: the parasagittal falx, convexities, sphenoidal ridge, tuberculum sellae, olfactory groove and cerebellopontine angle.¹⁻³

Meningiomas occur at a rate of about two in 100,000 and constitute 13 to 20 percent of all intracranial tumors. They may occur at any age, but predominate in adults with a peak incidence at age 45. They are more common in women and rare in children, accounting for one percent of the intracranial tumors in patients younger than 20. Small asymptomatic meningiomas are often found at autopsy in elderly patients.

Risk factors include ionizing radiation, head trauma, neurofibromatosis and certain viruses. An influence of endogenous and exogenous estrogen and progesterone is suspected but unproven. Other risk factors that have been studied with inconsistent results include glass, porcelain and ceramic workers and machinists, dental health care workers, workers in electrical and electronics indus-

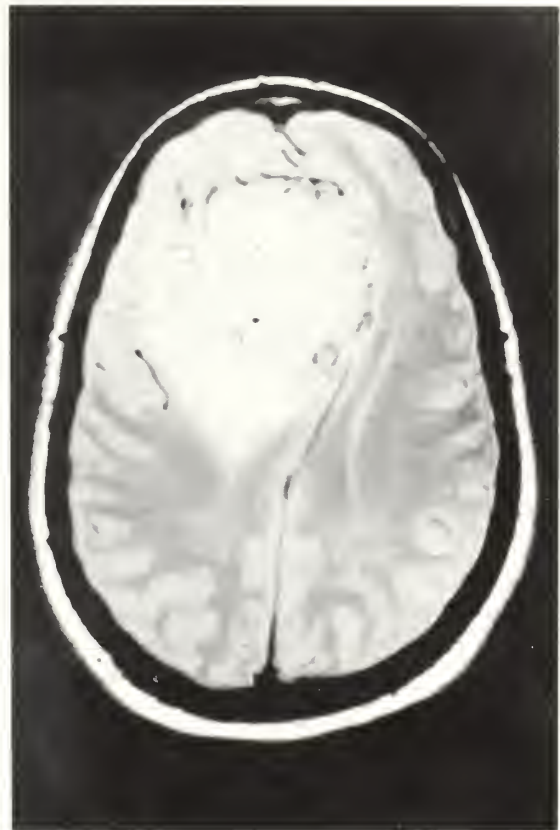


Figure 2. MRI scan showing frontal meningioma with midline shift.

tries, dietary N-nitroso compounds, vegetarian diet, cigarette smoking, alcohol consumption and elevated cholesterol.

Chromosome 22 is important in the pathogenesis of meningiomas; however, the precise gene has not been found.^{1,3,4,5}

Frontal meningiomas are notoriously "silent" and present with subtle psychological symptoms. These patients are often referred to psychiatrists for depression, anxiety, hypomania or schizophrenia. Interestingly, symptoms may respond to psychotropic medications. Patients may have a progressive change of intellect and personality. The diagnosis should be suspected in any fairly young person with no history of psychiatric disease who develops slowly progressive, psychological changes. Clues to the diagnosis may include the following:

- The patient may have led a previously well-ordered life.
- There is no clear reason why the patient

develops a psychiatric disorder.

- Family conflicts are precipitated by the patient's illness.
- The family insists the illness is physical.
- The patient may be diagnosed as depressed, but is more apathetic, careless and indifferent.
- Changes of affect such as instability, fatuity or euphoria are present.
- The patient develops memory failure, deterioration of personal appearance and professional duties.^{6,7}

Though frontal meningiomas are "silent" early on, certain physical signs may develop as the tumor grows. If the tumor invades the premotor area, the patient may develop seizures. Involvement of the left frontal lobe can cause hesitancy of speech, difficulty finding words and eventually dysphagia. Patients may also develop urinary frequency, nocturia and eventually incontinence of urine and feces. The can also develop headaches and visual changes, but these are usually late signs. A subfrontal tumor may cause anosmia. Fluctuating upper and lower extremity weakness and intermittent lower extremity weakness leading to falls and gait abnormalities has also been reported. Papilledema is a late sign. Plantar and tendon reflexes do not change unless the tumor invades the motor area. A grasp reflex develops early.⁶ Contralateral trigeminal neuralgia has also been reported.⁸

Frontal meningiomas are usually slowly progressive because this is a benign tumor that compresses the brain from outside. The personality and intellectual decline may develop over months to years. A meningioma that remained undiagnosed for 42 years has been reported. Eight percent of patients with parasagittal meningiomas have a history of symptoms for more than 10 years, the longest being 37 years. When the brain can no longer adapt, neurological deterioration may be rapid.⁶ Comadoll, et. al. reported four cases of elderly patients who developed neurologic symptoms after total joint replacement subsequently found to be due to frontal menin-

giomas. It was felt that fluid retention caused previously "silent" tumors to express themselves.⁹

Meningiomas are one of the few tumors that present characteristic changes in plain skull x-rays. They may show calcification within the tumor, hyperostosis, or blistering of the adjacent skull. In 50 to 60 percent of patients, the diagnosis can be suspected from changes on plain skull radiographs. CT or MRI is the procedure of choice. CT is 95 percent accurate in identifying the presence of these tumors. They present as homogenous, highly contrast-enhanced tumors with well-defined borders and often striking cerebral edema in the adjacent brain tissue.²

The prognosis is generally good if the tumor is detected early. Long-term survival and recurrence rates depend on the histological type, the size, location and extent of removal. The reported surgical mortality rate is as high as 14.3 percent and the reported 10-year survival rate after surgery varies from 43-77 percent. With apparent total removal, the recurrence rate varies from nine to 20 percent at 10 years, with subtotal resection varying from 18.4 to 50 percent. Radiation therapy is a useful adjunct to surgery. Anti-progesterone therapy has had some success and may be a future option for residual or recurrent meningiomas.⁵ □

ACKNOWLEDGMENT

Special thanks to Ginger Wideman for her help in preparing this manuscript.

REFERENCES

1. Cutler R. Scientific American; II(VI):1-4, 1983.
2. Rowland Lewis P, editor. Merritt's Textbook of Neurology Seventh edition. Lea & Febiger, Philadelphia, 1984.
3. Rosenberg RN, editor. Comprehensive Neurology. Raven Press, New York, 1991.
4. Longstreth WT, et. al. Epidemiology of intracranial meningiomas. Cancer ;72(3):639, 1993.
5. Black PM. Meningiomas. Neurosurgery, 32(4):643, 1993.
6. Maurice-Williams RS, Dunwoody G. Late diagnosis of frontal meningiomas presenting with psychiatric symptoms. British Medical Journal, 296:1785, 1988.
7. Sengstaken EA and King SA. Chronic schizophrenia or meningioma? JABFP, 7(1):71, 1994.

____ NAUSEA AND VOMITING ____

8. Florensa R, et. al. Contralateral trigeminal neuralgia as a false localized sign in intracranial tumors. Neurosurgery, 20:1, 1987.
9. Comadoll JL, et. al. Symptomatic intracranial meningiomas after total joint replacement. Case Reports, 14(3):347, 1991.

PHYSICIAN RESIDENT ALERT: IF YOU COULD USE OVER \$25,000 A YEAR— ANSWER THIS AD.

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

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Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral alpha-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

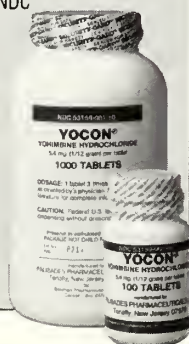
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon[®] 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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SCMA NEWSLETTER

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Joy Drennen, Editor
798-6207, in Columbia
Contributions welcomed
1-800-327-1021, outside Columbia

January 1995

MEDICARE UPDATE

By now you should have received the December, 1994 *Special Medicare Advisory*. This *Advisory* includes the detailed new guidelines for documentation and coding E/M services. You should also have received the 1995 HCPCS Update.

Guidelines for Documentation of E/M Services: In order to help you understand the implications of the new guidelines, Medicare will be conducting a series of training programs from January through April. On January 26, 1995, there will be a teleconference over the Health Communications Network (HCN) on channel "C" from noon until 1:00 pm. Dr. Ken DeHart of Myrtle Beach, who served on the National CPT Advisory Committee for E/M codes, and Dr. David P. Sheridan, Medical Director, Medicare Part B, will host the panel discussion. You can view the teleconference at any of the HCN sites listed on page 3 of the *Advisory*.

Since physicians write the office notes, we encourage you to be the ones who attend the training programs. Watch the *Medicare Advisories* for notification of E/M workshops to be held around the state in March and April.

Address Change for Participating Providers: Beginning January 1, 1995, all participating providers should mail claims to: Medicare, Part B Claims Processing, PO Box 100190, Columbia, SC 29202-3190. Non-participating physicians should continue mailing claims to the current address.

The January *Medicare Advisory* has been mailed. This *Advisory* is full of new information including electronic physical therapy services filing, changes and guidelines for antigen therapy and much more. You should read this *Advisory*, carefully.

Care Plan Oversight Services: Medicare will allow separate payment for care plan oversight services furnished on or after January 1, 1995 under the following conditions:

1. The services are furnished by a physician to a bene-

ficiary receiving Medicare-covered home health or hospice services;

2. The physician has furnished a service requiring a face-to-face encounter with the patient at least once in the six months prior to the first billing for the service; and
3. The physician does not have a significant financial relationship with the home health agency, is not the medical director or an employee of the hospice, and does not provide services under arrangement with the hospice.

If the above conditions are met, Medicare will:

1. Allow payment to one physician per patient per month for care plan oversight if it involves 30 or more minutes of the physician's time per calendar month.
2. Allow payment for 30 or more minutes of care plan oversight to a physician providing post-surgical care during the post-operative period only if the care plan oversight is documented to be unrelated to the surgery and billed with modifier -24.
3. Allow payment under CPT code 99375 only. CPT code 99376 will remain bundled since payment for care plan oversight services beyond 60 minutes per month is included in the payment for CPT code 99375.

Care plan oversight includes the following physician activities: development or revision of care plans; review of subsequent reports of patient status, review of related laboratory and other studies, communication with other health care professionals involved in the patient's care; integration of new information into the medical treatment plan, and/or adjustment of medical therapy. Care plan oversight does not include the routine pre- and post-service work associated with visits and procedures. Also, telephone calls with patients and/or their families are not included. Physicians claiming payment for care plan oversight services must document in their records the care plan oversight services they furnish, including the dates and exact duration of time spent on the services for which payment is claimed. Care plan oversight is recognized by Medicare as a physician service and must be provided and documented only by the responsible person.

(Continued on page 2)

MEDICARE UPDATE (Continued)

Multiple Surgical Procedures: HCFA has revised the multiple surgery rules effective January 1, 1995 to allow the lower of the submitted charge or 100 percent of the fee schedule amount for the first

procedure, and 50 percent for the second through the fifth procedure. Over five procedures requires a report for each. The special endoscopic rules have not changed. □

MEDICAID UPDATE

ICD-9 Diagnosis Codes: Beginning with dates of service on or after January 1, 1995, the Finance Commission will require the new 1994 ICD-9 diagnosis codes. Error code 760 or 761 (diagnosis code not covered on date of service) will be assigned to any claims for dates of service on or after January 1, 1995, which do not have a correct 1994 diagnosis code. **Note:** The 1994 edition of the ICD-9 was effective October 1, 1994. The 1994 edition contains the diagnosis codes effective through September 30, 1995, when the next edition of the ICD-9 will be published.

1995 CPT Codes: Effective with dates of service on or after January 1, 1995, the Finance Commission will accept the new 1995 CPT codes. Either the old 1994 or the new 1995 CPT procedure codes may be billed during the grace period from January 1, 1995 through March 31, 1995. Effective with dates of service on or after April 1, 1995, only the 1995 CPT procedure codes will be accepted.

Anesthesia Modifiers: Beginning April 1, 1995, the anesthesiologist and the medically directed CRNA will each be reimbursed 57.5 percent of the allowance

recognized for the anesthesia procedure if it were personally performed. The percentage will continue to be reduced by two and one-half percent each year, until 1998, at which time the allowance for the anesthesiologist and CRNA will be 50 percent of the reimbursement for a personally performed procedure.

A new modifier (QK) has been added for the medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals. This new modifier will be accepted with any claims which show dates of service on or after January 1, 1995. Either the previous modifiers (QJ, QO and QQ) or the new modifier QK may be billed during the grace period from January 1, 1995, through March 31, 1995. Effective April 1, 1995, modifier QK will be required.

Copper Intrauterine Device: Procedure code J7300 has been developed to replace procedure code S0085 (copper intrauterine device). Beginning with dates of service on or after January 1, 1995, either J7300 or S0085 may be billed until March 31, 1995. However, only procedure code J7300 will be accepted with dates of service on or after April 1, 1995. □

THE FIVE-YEAR REVIEW OF RBRVS

In 1989, Congress mandated HCFA to review RBRVS every five years to ensure that the fee schedule keeps pace with practice changes. This will be the first comprehensive review of the scale's relative values since the implementation of RBRVS in 1992. The revised fee schedule will be effective in 1997.

In the December 8th *Federal Register*, HCFA granted a 60-day period for physicians to notify HCFA in writing of procedures with a physician work component that is either under- or over-valued. These comments will be reviewed by the AMA/Specialty Society RVS Update Committee (RUC) whose recommendations will be forwarded to HCFA. RUC and HCFA will only review the comments that meet the criteria outlined in the *Federal Register*.

If you are interested in sending comments to HCFA about a particular code's relative value, please call 1-800-327-1021, ext. 253, or 798-6207, ext. 253 for a copy of the notice published in the December 8th *Federal Register*. All comments must be submitted by 5:00 pm, February 6, 1995.

PHYSICIANS CARE NETWORK UPDATE

Two more hospitals have contracted with the Physicians Care Network: Laurens County Health Care System in Clinton, and Loris Community Hospital and ECF.

Beginning January 6, 1995, updates to the PCN Provider Manual will be mailed to all participating providers' offices. In addition to new physician and ancillary-providers lists, you can expect some additions to the exhibits, especially the SI/IS criteria. *If you do not receive your update by February 6, 1995, please call Ginny Comer at ext. 242, 798-6207 in Columbia or 1-800-327-1021 statewide.*

DEA UPDATE

As of November 1, 1994, the United States Department of Justice Drug Enforcement Administration (DEA) opened a new Diversion Group in SC. The address is 1835 Assembly Street, Suite 1472, Columbia 29201. The telephone number is (803) 253-3441 or you can contact the Diversion Group at DEA Columbia's main number of (803) 765-5251. The Columbia Diversion Group will be available to answer any questions or concerns regarding DEA's regulations governing controlled substances.

New applications for registration, renewals of registration and other registration issues will continue to be handled by the DEA Atlanta Diversion Registration office. Ms. Sandy Chordash is the Registration Assistant for SC and may be reached at (404) 331-6493.

PALMETTO HEALTH INITIATIVE HOTLINE

Question: *How can I continue seeing Medicaid patients after the change in 1995/1996? (R. H. Hunt, MD, General Surgeon, Walterboro)*

Answer: Medicaid recipients will be phased into the Palmetto Health Initiative over a period of either 18 months or three to four years. Medicaid recipients who are waiting to be phased into the program will remain in the current fee-for-service Medicaid program. Therefore, you will continue seeing these patients as you do under the current system.

Once a Medicaid recipient is phased into the program, the individual will choose between two health plans. Under the Capitated Access Program (CAP), a fully capitated program covering most Medicaid services, the Medicaid recipient will be enrolled in an HMO and will choose a participating physician in that HMO. In order for you to see these patients, you need to be a participating physician with the HMO in your area enrolling Medicaid recipients.

Under the Physicians' Enhanced Program (PEP), a partially capitated program covering primary care services, the Medicaid recipient will choose one physician from a list of physicians participating in PEP in their area and accepting new patients. The selected physician will manage that patient's care by providing the covered primary care services for a monthly, capitated rate and by pre-approving any services not provided by that physician. Therefore, in order for you to see Medicaid patients enrolled in PEP, you need to be a physician participating in the PEP program or arrange a referral system with the PEP physicians who are serving as the gatekeeper. Any services provided outside the primary care benefits package will be reimbursed fee-for-service.

All physicians may participate in the PEP program. CAP program participants must be members of the HMO provider panel.

Please call the Palmetto Health Initiative Hotline (1-800-825-7821) with your questions regarding the Medicaid waiver. SCMA staff will respond to your question in writing within five working days. ☐

DOMESTIC VIOLENCE VICTIMS OFFERED FREE SURGERY BY FACIAL PLASTIC SURGEONS

In 1994 the American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS), in partnership with the National Coalition Against Family Violence (NCAFV), created the National Domestic Violence Project in an effort to help women break out of the cycle of violence, enhance their self-esteem and aid them in rebuilding their lives. The National Violence Project provides free facial and plastic reconstructive surgery to victims of domestic violence who receive facial injuries and for reasons of shame, low esteem, and/or financial reasons are not able to receive adequate care.

In SC, Doctors Paul T. Davis of Florence, Marcelo Hochman of Charleston; and James F. White of Columbia have enrolled in this program to utilize their skill, dedication and compassion to help victims of domestic abuse. The National Violence Project has a centralized information center accessible through a toll free number (1-800-842-4546) which provides the names of surgeons in a victim's area who will provide free consultation and perform surgery if needed. □

WORKSHOPS/CONFERENCES

The SCMA is presenting a workshop for physicians and their staff on "How to Collect Fees Promptly." It will be held on February 8, 1995 from 9:00 am until 4:00 pm at the Sheraton Columbia Hotel and Conference Center at the intersection of I-20 and Bush River Road. If you did not receive a brochure and registration form by mail, call Ginny Comer, ext. 242, 798-6207 in Columbia, or 1-800-327-1021 statewide. The registration fee for SCMA members is \$95 before January 18, 1995 or \$120 after January 18. It includes lunch, refreshments and handouts.

Interfaith Community Services of SC, the SC Christian Action Council, and the SC Healthy People 2000 Coalition is presenting a conference on "Faith at Work for Healthier Communities," on February 18, 1995 at North Trenholm Baptist Church in Columbia from 8:30 am until 4:00 pm. Featured speakers are Gary Gunderson from the Carter Center in Atlanta, GA, and John Hatch from the School of Public Health, University of North Carolina at Chapel Hill. *For further information, call Melanie Ellerbe (803) 252-8390 in Columbia, or 1-800-879-2219 statewide.*

A Low Vision Aids Seminar will be held February 24 and 25 on the Richland Memorial Hospital (RMH) Campus in Columbia. The seminar is sponsored by the Networking Visual Support Group of the Department of Volunteer Services, RMH, and the SC Eye Institute. There is no charge for this seminar. *Contact Mary Lou Nay in Columbia at (803) 794-9461.* □

AMA GUIDELINES HELP PHYSICIANS ASSIST PEOPLE WITH DISABILITIES

The AMA has released guidelines that will help physicians use new assistive technology – devices and services that will improve the quality of life for the nearly 500 million Americans with disabilities.

"Guidelines for the Use of Assistive Technology: Evaluation, Referral, Prescription" will serve as a quick reference for primary care physicians responsible for prescribing assistive devices and services for their disabled patients. Guidelines will also be used as part of a larger curriculum for 10 training sessions held in five cities through the US this year. The interactive workshops and the Guidelines will cover:

- * Role of physician in the physician-patient relationship.
- * Patient assessment – screening patients for functional impairment.
- * Individual roles, team concept and the rehabilitation process.
 - * Matching the patient to the device.
- * Prescription and certification of medical necessity.
- * State assistive technology and other resources.

The Guidelines cost \$5 each or can be purchased in bulk from the AMA Department of Geriatric Health, AMA, 515 N. State Street, Chicago, IL 60610. For more information, call (312) 464-5095.



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HENRY JEFFERSON STUCKEY, M. D. (1886-1975): A REMEMBRANCE

MICHAEL C. WATSON, M. D.*

I first met Dr. "H. J." Stuckey in April of 1954. I was finishing a visit to Bamberg to decide if I would like to settle down there to practice. I did and Dr. Stuckey became a significant person in my new life as he soon "took me under his wing."

Dr. Stuckey was "retired" after having had a "heart attack" prior to my coming to Bamberg. He and I hit it off extremely well and he decided he would go into practice again, if I would help him. As I was not at all busy, this suited me fine. Anything was better to do than nothing. Things began to pick up for me as his patients realized that he wanted them to see me when he was not available, which was often.

Dr. Stuckey began practicing again in the hospital as well. One day he came into the hospital and said, "Doctor, do you want to see a boy who is dying?" We went into the emergency room where there was a two to three-year-old black child who was dying. He was greatly dehydrated and the history was that of severe and unremitting diarrhea for several hours. As quickly as I could I did a cutdown (placing an intravenous catheter in a vein under direct vision through an incision just above the ankle) and began to give him intravenous fluid as fast as possible. After he was successfully resuscitated and no longer in shock, I gathered more information and realized he probably was suffering from arsenic poisoning. (Arsenic was a common ingredient in mouse and rat poison at that time.) There was no way for me to prove this and so I had the hospital secure some BAL (British AntiLewisite), a chelating agent that binds and removes heavy metals from the body.

This was administered as quickly as possi-

ble and the little boy recovered rapidly and after a hospital stay of a little over a week, was discharged. Several months later, I had X-rays of his long bones and, sure enough, there were heavy lines above each of the epiphyses (growth centers) of the bones proving the insult was due to heavy metal poisoning.

Dr. Stuckey was very impressed by this performance as he had been sure the boy would be dead in a few minutes. This event did something else, as well. He told me later that when he watched me work, he realized that he wouldn't have been able to do this and the boy would have died. This made him more "dependent" on me than ever, if he was to continue to practice.

One of his longtime patients came to see him to ask if he would deliver her baby. (He had not practiced obstetrics since his retirement.) He told her about me and said that we worked together and I would give her the prenatal care and "one of us" would deliver her. She was satisfied and showed up in my office for prenatal care before Dr. Stuckey had told me of this arrangement. The deal was that our fee was \$50 and we would split it no matter who delivered the patient. (He never did.) All of these patients who came to him for this care would pay him, up front, and he would give me \$25. My feeling was, "Half a loaf is better than none."

All of the older physicians saw patients in their homes at night and on the weekend. The patients were accustomed to calling or coming by if they were ill. I never did this as I didn't feel good about a parade of sick patients through my house at any time of the day or night. I felt that it would put my family at threat for all kinds of things. I would meet them in the emergency room or in my office, but never in my house.

*PO Drawer 528, Bamberg, SC 29003.

Dr. Stuckey said that one night a knock came at his door and a man there said his brother was in the back seat of his car and was sick. Would the doctor come out to the car and check him? Dr. Stuckey went out and, sure enough, there was the man sitting upright on the back seat, unconscious. He leaned in the car and pulled the man's lower eyelid down to check his pupil. The diagnosis of acute alcoholism became clear when the patient opened both eyes and cursed Dr. Stuckey with great vigor and enthusiasm. This infuriated Dr. Stuckey who caught the patient in the front of his shirt, snatched him out of the car, hit him in the face with his fist and dropped him in the gutter. The brother picked up the patient and put him back in the car and said, "How much do I owe you, doctor?" Dr. Stuckey said, "\$3.00." With that the brother gave him \$3.00, got in the car and drove off.

Everything seemed to me to come out right with Dr. Stuckey. Once I was in the hospital and Dr. Stuckey said, "Come to the delivery room with me. I have to do an internal podalic version and breech extraction." (Today, not less than 100 percent of the obstetrical community would consider C-section mandatory treatment for this problem.)

I immediately began to break out in a cold sweat. Not even in my wildest nightmares had I ever thought I would be a participant in such a high-risk procedure. I had not only never seen this done but prior to today, had never known anyone who had ever seen it performed. As I went into the delivery room, I had visions of Dr. Stuckey (whom I considered "old and feeble") fainting or passing out from exhaustion and leaving me to deal with this situation alone. As soon as the patient was positioned on the table and I had prepped and draped her, he began the version. I don't believe the patient had any analgesia much less anesthesia. Everything went very smoothly with a certain amount of pulling and tugging that required all his strength. As he began the breech extraction after a successful version, it was obvious that he was exhausted so I took over and performed the

extraction, which, thankfully, I had done a number of times previously. After I delivered the baby and the placenta, a column of blood came from the vagina at a frightening rate. Dr. Stuckey paid it absolutely no attention and almost immediately, it stopped. By this time, I was almost a basket case!

On another occasion, Dr. John McLaughlin, who practiced in Ehrhardt, asked me to come to the emergency room to see a patient with him. When I arrived I found him and a patient who had delivered at home a little while before. The problem was that of a retained placenta which had defeated all of John's efforts at delivering at home and in the emergency room. I secretly prided myself on being able to handle this kind of problem. In spite of all my efforts and maneuvers, however, the placenta remained firmly in the uterus. I felt that this was a setup for disaster as the delivery had been done by a lay midwife and would have to be considered unsterile. This would prohibit any instrumentation through the vagina. I said, "John, I believe we are going to have to recommend that this patient have an immediate hysterectomy."

Just at that time, the door opened and Dr. Stuckey walked in. He frequently did this "just to see what you boys are up to." He asked what the problem was. We told him and he walked over to the patient and put his hand on her abdomen. At this point the patient expelled the placenta as if it were shot from a gun! We were thunderstruck, but he just laughed as he walked out leaving John and me just looking at each other. Then we both burst out laughing.

Dr. Stuckey told me of being called to the home of a boy who had suffered a large laceration of his leg in the barnyard. When he arrived he found that the family had become alarmed at the loss of blood and wanting to staunch the flow of blood quickly, had packed the wound with manure.

I was horrified! The tetanus bacillus is a normal inhabitant of the bowel of most farm animals in the first place and the accident occurred prior to any tetanus vaccine, much

less tetanus immune globulin. This was a real setup for disaster. With my stomach in knots, I asked, "What did you do?" He looked surprised at the question. "Why I gave him some chloroform and cut his leg off."

Another time he was called to the "lot" (barnyard) to treat a boy that was kicked by a mule. He found the boy lying unconscious right where he had fallen. Examining the area of the head that had received the blow, he discovered a depressed fragment of skull. He said, "I reached in my bag and got an instrument and worked it around under the fragment. I was able to pop that piece of bone out. Immediately the boy sat up and said, 'Whoa'."

Then he explained, "That boy saw what the mule was about to do and began to say, 'Whoa;' however, before he could say it, the mule kicked him. The bone fragment trapped that word right there until I released the pressure and then the word continued through the brain and the boy said, 'Whoa'."

Dr. Stuckey never had any children of his own, but he loved everyone else's and all the children loved him. I saw evidence of this many times as we worked together. He told me that in the past he had kept a herd of milk goats. When he realized that an infant was intolerant to cow's milk, he loaned the family one or two of the "nannies" to supply the infant with tolerable milk as this was in the days prior to readmixed infant formula being available. Most of the formulas used were based on evaporated cow's milk.

One day I got a call from Dr. Stuckey. He told me that he had been treating a little boy at home for several days and he didn't seem to be getting any better. Would I go by and check him and see if he needed anything. Of course, I agreed to do this.

When I arrived at the home and examined the little boy, who was about four years old, I found that he had asthma and bronchitis, for which Dr. Stuckey had been treating him with oral medications. I also found that he had not been eating or drinking for several days and was badly dehydrated.

I called Dr. Stuckey and explained what I

thought the problem was. I suggested that he probably would improve more rapidly if he were admitted to the hospital and given intravenous fluids. I also suggested that if he were in the hospital he could be given antibiotics by injection. He agreed and said, "Would you admit him to the hospital and get all these things started for me?" I agreed.

I followed the family to the hospital and saw that the little boy, who was frightened out of his wits by this move, was admitted, his chest X-rayed, intravenous fluids started, the antibiotics administered by injection and blood was drawn for the necessary laboratory studies. By this time, the little patient had assumed that all those he held dear had turned against him and he was dreading what would come next. He was crying so vigorously that he could be heard all over the hospital.

The door opened and Dr. Stuckey came in. He walked straight over to the bed, gathered the little patient up in his arms and said, "That's all right, little fellow. It's going to be all right. Dr. Stuckey is here now and he's not going to let any of these mean doctors and nurses do anything else to you!"

I received a call one day to go to a home to see a sick child. When I got there, it was in the poorer, mostly black, section of town, which this family was. I went inside and was greeted by the mother, who was holding tightly to the patient, a little boy about six years old. In response to my questions, she said the child had been sick with fever for several days. Dr. Stuckey had been by the day before and said that he had a sore throat and had given him an injection of penicillin. In response to my question as to why she called me as the child was already being treated by Dr. Stuckey, she said, "Dr. Stuckey said I should call you. He had a time catching this boy when he found out that he was going to give him a shot. He finally trapped him under the house by the chimney before he could give him the shot. He said he was just getting too old for this and I was to call you."

Dr. Stuckey was not quick to give up!

Dr. Stuckey said that one day as he was stand-

ing on the street, a man approached him and said, "Doctor, would you mind coming out to see my brother? Two other doctors have seen him and 'given him up.' They say he has 'locked bowels' (intestinal obstruction) and there is nothing more that they can do." (In those early days, hospitalization and consultation required a trip to Columbia by railroad and was very expensive.)

Dr. Stuckey loved a challenge and told the man he would come that day.

When he arrived and examined the patient, he agreed with the diagnosis. The patient's brother asked, "What am I going to do?" Dr. Stuckey told him, "Go to town and get two new plow-lines (soft cotton ropes), a rectal tube and a gallon of heavy mineral oil. When you get back, pad his ankles well, tie a plow-line around his ankles and throw the ends across the rafters. (The room was not "sealed" with a ceiling, but had exposed rafters.) Then pull him up until his fingertips can just touch the floor. Put the rectal tube into his rectum and pour in the mineral oil. When the oil drips out of his mouth, cut him down."

Dr. Stuckey saw the brother across the street in town several weeks later. He shouted across the street, "Dr. Stuckey, we did just what you said and things happened just like you said they would. Thank you, Doctor. My brother is fine!"

Voodoo and "hexes" were still seen occasionally when I came to Bamberg, but Dr. Stuckey had a number of experiences with that phenomenon. The one I remember best is when Dr. Stuckey was asked to see a patient who was "hexed" and the family was afraid for her life.

He went to her home and found the patient totally unconscious and not responding to any stimulus, no matter how vigorous. She had been in this condition for a number of days and had not eaten or drunk anything.

Dr. Stuckey examined her well and said to the family, "Go out and catch two 'frizzle-legged chickens' (these are chickens whose feathers grow down over their feet and are not bare-legged like most are). Pull out five

tail feathers from each. Get 10 small pieces of fat 'light-wood' and put this out by your wash-pot. Make a small tent of the wood and lean the feathers against it. Then set it on fire and let it burn completely up. In the morning, the chickens will come and scratch this up and she will be well."

Events occurred exactly as he had said and the next morning when the family looked out and saw the chickens scratching the ashes, they went into the patient's room very excitedly talking about this. The patient opened her eyes, looked about and was soon eating breakfast and laughing and talking.

He told me that he was there late in the afternoon and the chickens were already going to roost and he said, "Chickens love more than anything to scratch in new ashes."

I had only been in Bamberg for three or four years and was ill with the 'flu' when I received a call one night to go to see an old man named Moss, whom I had seen several times before. The only information I could get over the telephone was that he was "bad off, Doctor, please hurry." In spite of having fever of 103, I got up and went to see him about five miles out of town. I had treated him several times before for asthma, but when I arrived, I found him lying in bed, enjoying the attention and without a wheeze in his chest. In fact, I couldn't find anything wrong with him. His temperature was normal as was his blood pressure. I could find no problem at all. I tried to conceal my irritation at having been called out on a 'false alarm' and told the family that he was not going to die and that I could find nothing wrong with him. They said, "But doctor, he says he is going to die and for us to call all the children!" I said, "Well, he is not going to die because there is nothing wrong with him."

Two days later, the local undertaker brought me his death certificate for my signature.

About eight months later, one of the maids at the hospital came to me and said, "Doctor, would you come out and check Mama? She says she is going to die and for us to call the children home." I replied, "She just might

die. Please bring her to the emergency room so I can examine her because we might have to put her in the hospital." I resolved not to be caught again if I could help it.

Mama was brought to the hospital where I examined her and my worst fears were confirmed. I could find nothing wrong with her. Not only was there nothing wrong with Mama on physical examination, but all the tests and X-rays I ordered were within normal limits. Remembering that Moss had died promptly after the last child arrived, I felt that I was in a race with the time her last child arrived.

Dr. Stuckey came into the hospital and I asked him to see this patient "who was going to die." He checked her over and looked over the chart and said, "This woman is not going to die. There is nothing wrong with her."

Two days later the last child arrived and spoke to the patient who died that same day.

One day Dr. Stuckey and I were standing in front of the hospital and he told me the following tale.

This incident must have occurred around 1920 or before when he was visiting a patient in the first hospital built in Orangeburg. While he was there an emergency case came into the emergency room. He was the only physician in the building so the nurse asked if he would see this patient and he did.

It seems that there was an industry of some

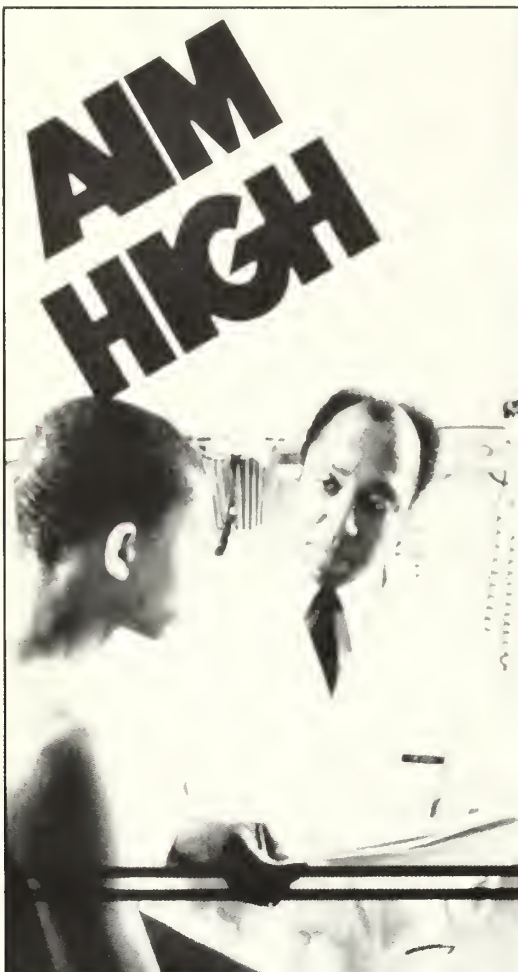
kind in Orangeburg that utilized logs. One of the steps in the process was to put the logs in a huge vat of boiling liquid. It seems that the patient worked in this part of the plant and had the immense misfortune to fall into and become submerged in this boiling liquid. When seen by Dr. Stuckey, he was perfectly conscious and free of pain indicating that he had suffered deep third degree burns over his entire body and recovery was impossible. He faced a short and horrible life expectancy.

Dr. Stuckey sized up the situation and asked the patient, "Are you right with God?" The patient answered that he was. Dr. Stuckey then said, "Let's say the Lord's Prayer together." And they did. "Then," said Dr. Stuckey, "I gave him ether until he was dead."

Things were different then.

7

(Henry Jefferson Stuckey was born in Lee County, S. C., February 11, 1886. He graduated from Bishopville High School, attended Davidson College, and graduated from the Medical College of South Carolina in 1910. He came to Bamberg in 1911 and associated himself with Dr. J. J. Cleckley in the practice of medicine. Dr. Cleckley died in an influenza epidemic in 1918 and he was in practice alone until his final retirement in 1970. He died on August 10, 1975.)



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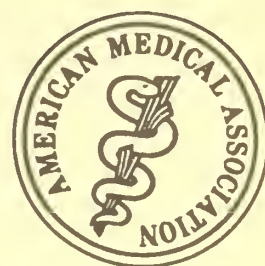
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**THE INTERIM MEETING OF THE AMA
HONOLULU, HAWAII
DECEMBER 2-7, 1994**

REPORT OF THE SCMA DELEGATION

WALTER J. ROBERTS, JR., M. D.*



The 1994 Interim Meeting of the House of Delegates of the American Medical Association was held in Honolulu, Hawaii December 4-7, 1994. The meeting was attended by all members of the South Carolina delegation, by SCMA President Marion Burton, President-Elect Ned Nicholson and Treasurer Carol Nichols. Also in attendance was our CEO Bill Mahon. Drs. March Seabrook and Dina Grice, delegates to the Young Physicians Section of AMA, attended that meeting, which was held just prior to the meeting of the AMA House of Delegates. Dr. Seabrook's comments are printed on page 4 of this report.

South Carolina's Board of Trustees member, Dr. Randolph Smoak, continues his rise as a major player at the national level on behalf of the physicians of our state. In addition to his increasing visibility as a spokesman on vital issues for AMA—most recently regarding AMA's fight against the tobacco interests—Randy has become the chairman of the AMA board's finance committee, a very important position. We are proud of his accomplishments and appreciative of his commitment.

As is the consistent format for the S. C. Delegation, the numerous reports and resolutions presented to the House of Delegates were carefully reviewed and critiqued prior to the meeting. I am always proud of the delegation's understanding and knowledge of the issues, and their willingness to address these problems on behalf of South Carolina physicians. South Carolina had

no resolutions to present at this meeting, but many of the prior resolutions which have sprung from the actions of the South Carolina Medical Association House of Delegates are helping shape AMA policy as it evolves. Worthy of mention in this regard are the proposals South Carolina has made in the ongoing efforts at restructuring Medicare, and our resolution from the Annual Meeting demanding that the Medicare's usage of the Resource-Based Relative Value System (RBRVS) be a formula for an appropriate method of compensating physicians for their services, and not as a cost containment tool for governmental programs.

In my opinion, the interim meeting of the AMA House of Delegates was marked by two important events: one, the failure in the effort of President Clinton and his supporters in Congress to secure their goals in Health Care Reform; and two, the resounding success of the Republican party in the November congressional elections. These two occurrences have led to significant reshaping of AMA's approach to its ideas with respect to Health Systems Reform, and has demanding implications on AMA's approach toward issues such as insurance reform, tort reform and anti-trust relief.

Also in my opinion, the business of Medicine—as opposed to the science and “profession” of Medicine—is fraught with ambivalence as never before. The most visible and debated of these ambivalences is the burgeoning increase and penetration of “Managed Care” in our practices. Clearly, AMA is on the horns of a great dilem-

*207 Spring Valley Road, Columbia, SC 29223.

ma in its continued efforts at supporting fee-for-service medicine, while its constituency, the physician population of the country, daily becomes more and more dependent on managed care contracts to remain financially functional and even viable.

HEALTH SYSTEMS REFORM

As stated above, the demise of President Clinton's Health Reform plan has had an impact on AMA's program as well. It should be remembered that AMA began as far back as 1989 with the premise that something had to be done about the Health System with particular respect to access of every American citizen to appropriate medical care. Also implicit in the concern was the ever-increasing cost of medical care, as it consumed more and more of the Gross National Product. From these concerns sprang AMA's *Health Access America*, our plan for Health Systems Reform. It should also be remembered that much of President Clinton's plan arose from ideas advanced by *Health Access America*.

In light of this event, the AMA is now backing what has come to be known as "incremental reform" of Health Care. Universal coverage is viewed as something to be hoped for in the future, but not a viable goal at present. Insurance reform is a bandied-about term which is certainly needed and should be sought. Tort reform, perhaps in the realm of federal initiatives, will continue to be pursued. (It should be recognized by South Carolina physicians that in most parts of the country, unlike South Carolina, medical liability continues to be a raging, costly practice issue). Anti-trust relief for physicians clearly remains another goal for "incremental reform," since physicians need and deserve the right to bargain collectively in their effort to preserve their practices.

Finally, AMA reform priorities include ideas for helping our patients in the area of financing health care. The creation of Medical Savings

Accounts is a much discussed plan, hopefully to be designed to encourage individual responsibility for health care decisions. Also, it is hoped that tax-relief, at least equal to what large industries enjoy in purchasing health insurance for their employees, can be afforded small businesses and individual purchasers.

MANAGED CARE

The AMA Board of Trustees presented to the House of Delegates a long and detailed report describing trends in Managed Care. As stated previously, though there continues to be emotional support for fee-for-service medicine, and a prevailing sentiment that, all things considered, fee-for-service medicine should be best for patient/physician quality care concerns, AMA recognizes the reality of ever-increasing expansion of managed care throughout the country. Indeed, in many areas of the country, managed care is the rule rather than an exceptional mode of providing health care benefits.

The House of Delegates adopted a resolution with respect to the impact of managed care which basically supports the proposals of the "Patient Protection Act." This Act, which has wide support in Congress, embodies principles to protect the patient from sacrificing quality health care for the sake of financial saving, those savings often benefitting some entity such as an insurance company or privately-owned HMO rather than the patient. It is hoped that there will be state as well as federal support for the Patient Protection Act, since it appears that as health systems reform occurs, and as managed care penetration advances, the states will be the preeminent player and decision-maker.

The continued problem regarding "any willing provider" laws remains. As I have said before, it is a "two-edged sword," no simple answer available, in my opinion. AMA does cling to several premises which make good sense, however. These include demanding that managed care

plans publicize their standards for accepting panel physician members, that a physician who qualifies under those standards be allowed to at the very least apply for such a panel if he desires, and that any reason for "de-selecting" or terminating a physician's participation in the plan, other than quality, be clearly defined.

ETHICS COUNCIL DECISIONS

Of the seven Councils of AMA, one is certainly unique in its function and its responsibility. It is also unique in its autonomy. That Council is the Council on Ethical and Judicial Affairs ("CEJA"). CEJA's opinions are widely quoted as AMA's official statements regarding ethical affairs, but the AMA House of Delegates does not always agree with those opinions. When there is a difference of opinion, however, CEJA does not have to "change its mind." This has given rise in the past to much interesting and stirring debate. A resolution was introduced by Louisiana which would make ethical opinions by CEJA subject to approval by the House of Delegates, but was not adopted.

CEJA was not, however, unresponsive to the issues raised, and has set forth to be more open to input by physician members. Included in this will be clearer delineation of what ethical questions are being raised, what agenda is planned and who is planning it, and more open dialogue with the House in its opinions. Ultimately, however, the ethical decisions will remain the province of CEJA, as before.

Several important ethical opinions were announced, with much discussion of these in Reference Committee. Removal of organs for donation from Anencephalic infants was deemed ethical by CEJA, as was a pilot project called The Pittsburgh Protocol, where organ donation done immediately following removal of life support is carried out under operating room conditions.

OTHER ISSUES

A number of other issues resulted in resolutions or will generate further reports from the Board of Trustees or from the other councils. A resolution was adopted to call for repeal of the McCarren-Ferguson Act, which gives the insurance industry anti-trust exemption which it utilizes unfairly. Another resolution called for federal legislation, when requested by state medical societies, to secure waivers from ERISA regulations, and to help secure Medicaid waivers when needed, to allow states to implement health systems reform. I will once more refer you to the December 1994 issue of *AM News*, which discusses many of these items and many others you will find interesting and important to you at greater length.

May I once more thank you, on behalf of your South Carolina AMA Delegation, for the opportunity to serve you. We are committed to being a strong and visible delegation, and to do our best to make AMA strong. Please do not hesitate to call me or any of the delegation about any of your concerns or ideas. We will see that those concerns and ideas are heard at a national level.

**REPORT FROM THE YOUNG PHYSICIANS SECTION
1994 INTERIM AMERICAN MEDICAL ASSOCIATION MEETING
HONOLULU, HAWAII
DECEMBER 1-3, 1994**

MARCH SEABROOK, M. D.

Great news from the AMA Interim meeting! A young physician will soon be on the AMA Board of Trustees. This action culminates a two-year campaign to increase the diversity on the AMA Board of Trustees. An intense grassroots effort by the young physicians has succeeded, and a young physician will be elected at the Annual Meeting in June, 1995. The Board of Trustees will not only include a young physician, but also Dr. Randy Smoak, a surgeon from Orangeburg, who is completing his first term as a board member. With the rapid changes in health care delivery it is crucial that our concerns are heard at every level.

The Young Physicians Section assembly conducted its business December 1-3 in Honolulu. South Carolina was represented by March Seabrook, M. D., (Gastroenterologist, Columbia) and Dina Grice, M. D., (Dermatology, Columbia). The main purpose of the assembly is to devel-

op policy for this Section as well as to promote the involvement of young physicians within organized medicine.

We heard debate on a total of 20 resolutions and six reports. The issues addressed included emergency department utilization, state-directed health care reform, medical saving accounts, "any willing provider" legislation, ethical use of placebo controls and restricted covenants, among others. An issue that generated a significant amount of debate was regarding exclusion of young physicians from joining closed HMOs. We have not experienced a significant amount of this in South Carolina, however, this is becoming a major problem in the west and the northeast.

I have enjoyed serving as your delegate and urge you to continue your support of the SCMA and AMA in the upcoming year. ☐

Editorials

TOWARD A POST-ANTIBIOTIC ERA?

Resistant microorganisms do not recognize geographic boundaries. Inappropriate or excessive use of antimicrobial drugs by any person or practitioner can affect the entire ecosystem and cannot be condoned.

—Calvin M. Kunin, M. D.¹

Such pronouncements as Dr. Kunin's are hardly new. We agree in principle, but sadly shake our heads. Yes, ideally physicians should be extremely circumspect about prescribing antibiotics on an empiric basis. Yes, such prescribing habits foster the emergence of drug-resistant microorganisms. But, no, it is not an easy matter to convince individual patients of the virtues of therapeutic restraint. I recall the time, 20 years ago and fresh out of an infectious disease fellowship, when I declined to prescribe antibiotics over the telephone for what sounded like a clear-cut viral upper respiratory infection. The patient soon complained to one of my partners: "I don't care what *that* doctor said—tetracycline helps my cold!"

Yet there are now new grounds for concern. Such phenomena as multidrug-resistant tubercle bacilli, penicillin-resistant pneumococci, and—most especially—vancomycin-resistant enterococci raise the grim possibility that we may be rapidly heading toward a post-antibiotic era. No new classes of antibiotics are on the horizon. We are rapidly exhausting the old ones. Some evolutionary biologists suggest that the "age of antibiotics" may eventually prove to have been a transient phenomenon. We humans seem to have enormously reckless appetites for whatever makes us feel good, and we are not accustomed to denying resources to individuals who are able to afford it. Recently, *Newsweek* screamed on its cover: "Antibiotics: The End of Miracle Drugs?"² Sensational journalism? Possibly—but serious scientists are raising the same issue.

Let us briefly review some of the current issues:

- *Methicillin-resistant Staphylococcus aureus* (MRSA): These staphylococci are no more virulent than methicillin-sensitive strains, but require vancomycin for definitive treatment. Having a unique penicillin binding protein known as PBP2a, they are more properly called "broadly-beta-lactam-resistant" since neither penicillins nor cephalosporins are likely to work irrespective of *in vitro* sensitivity results. Their frequency continues to increase at many centers. Prior use of quinolone antibiotics appears to be a risk factor; in one study, patients who had received quinolones (such as ciprofloxacin or ofloxacin) were four times more likely to acquire MRSA infection compared to patients who had not been treated with quinolones.³ Despite the common practice, patients should not be excluded from nursing homes or other long-term care facilities just because they are colonized with MRSA.⁴

- *Methicillin-resistant coagulase-negative staphylococci* (MRSE—for "methicillin-resistant *S. epidermidis*): These staphylococci continue to be the implant surgeon's nemesis. More than 50 percent of coagulase-negative staphylococcal isolates at most U. S. hospitals are methicillin-resistant. The situation is similar to that with MRSA in at least three respects: (1) the mechanism of resistance is a penicillin binding protein with reduced affinity for beta-lactam antibiotics; (2) cephalosporins and other beta-lactam antibiotics are unlikely to be effective clinically even when *in vitro* susceptibility results suggest otherwise; and (3) vancomycin is the drug of choice. And unfortunately, the slime that

MRSE strains form around foreign bodies can actually inactivate vancomycin!

- *Penicillin-resistant pneumococci* (PRSP — for “penicillin-resistant *S. pneumoniae*): Until recently, pneumococci with high-level resistance to penicillin G were infrequent in the United States. Today, strains with low-level resistance (MIC’s 0.1 to 1.0 mcg/ml) are relatively common, and the incidence of higher-level resistance is increasing fairly rapidly.⁵ Again, the molecular basis consists of penicillin-binding proteins with reduced affinity for the antibiotic. Although third-generation cephalosporins such as cefotaxime and ceftriaxone often provide successful therapy, cases of meningitis due to strains resistant to all of the beta-lactams have now been reported.

- *Vancomycin-resistant enterococci* (VREF — for “vancomycin-resistant *Enterococcus faecium*): Only three antibiotics have, historically, been reliably effective against enterococci: penicillin G, ampicillin, and vancomycin. Because none of these agents is actually bactericidal against enterococci, it has been customary to add an aminoglycoside for infections such as endocarditis in which it is necessary to assure that the bacteria are killed rather than just inhibited. Penicillinase-producing enterococci have now been reported. Now, vancomycin-resistant enterococci are on the scene and are actually increasing dramatically in the intensive care units of our larger hospitals.

The last of these observations is the scariest of all for several reasons:

- Enterococci are now the third most common nosocomial pathogens at most United States hospitals, and the virulence of these bacteria seems to be increasing.
- Enterococci resistant to aminoglycosides, beta-lactams, and vancomycin are—for all intents and purposes—*untreatable*.
- Should enterococci confer the genetic material responsible for vancomycin resistance to staphylococci, we would be confronted with essentially untreatable *S. aureus* infections. Given the ubiquity of *S. aureus*, the apparent increasing virulence

of this historically versatile pathogen (as evidenced by the toxic shock syndrome), and the presence in our midst of an increasingly vulnerable patient population, the implications of this specter are almost unthinkable.

Although gram-positive cocci have received the most attention in recent years, there are of course many other considerations. Aerobic gram-negative rods (such as the Enterobacteriaceae and Pseudomonadaceae) are increasingly resistant to beta-lactam antibiotics, including the newer ones. A few isolates of penicillinase-producing meningococci have been described, raising the frightening possibility of meningococcal disease resistant to the beta-lactam agents. Widespread use of acyclovir for *Herpes simplex* infections has spawned resistant mutants. Widespread use of antiretroviral drugs (AZT, ddI, ddC) for HIV infection has spawned resistance to the extent that some experts now caution that we withhold these drugs until patients become symptomatic. Widespread use of antifungal drugs in our hospitals has spawned *Candida* strains resistant to amphotericin B and—more recently—to fluconazole. Widespread use of prophylaxis directed against parasites such as *Pneumocystis carinii* and *Toxoplasma gondii* for HIV-infected patients introduces the potential that these, too, could develop resistance—and unfortunately, we have few ways to screen for such resistance until it is too late.

What can be done? Obviously, there is a need to search for newer and better antibiotics and to search for effective vaccines. But equally obviously, there is a need for us to re-evaluate the impact of antibiotic prescribing practices. Would rotating antibiotics make sense? Would developing more stringent algorithms for antibiotic prescribing help? Would promoting public awareness help? One recent reviewer concluded:

The responsibility of reducing resistance lies with the physician who uses antimicrobial agents and with patients who demand antibiotics when the illness is viral and

when antibiotics are not indicated.⁶

Individually, we must continue to try to exercise restraint. Collectively, we must oppose efforts by certain parties to promote further licensing of over-the-counter use of antibiotics without a physician's prescription. Failure in this area would be an enormous setback to the medical progress that both we and the public so often take for granted.

—CSB

REFERENCES

1. Kunin CM: Resistance to antimicrobial drugs — a worldwide calamity. *Ann Intern Med* 118: 557-561, 1993.
2. Newsweek, March 28, 1994.
3. Webb R, Nolan R, Spruill E, et al: Quinolone use and methicillin-resistant *Staphylococcus aureus* infection. Proceedings of the 33rd Interscience Conference on Antimicrobial Agents and Chemotherapy, 1993 (abstract 629).
4. Mulligan ME, Murray-Leisure KA, Ribner BS, et al: Methicillin-resistant *Staphylococcus aureus*: A consensus review of the microbiology, pathogenesis, and epidemiology with implications for prevention and management. *Am J Med* 94: 313-328, 1993.
5. Breiman RF, Butler JC, Tenover FC, et al: Emergence of drug-resistant pneumococcal infections in the United States. *JAMA* 271: 1831-1835, 1994.
6. Neu HC: The crisis in antibiotic resistance. *Science* 257: 1064-1073, 1992.

TABLE
RESISTANCE OF BACTERIA TO ANTIBIOTICS: CURRENT AND FUTURE CRISES⁶

ANTIBIOTICS	CURRENT CRISES	FUTURE CRISES
Beta-lactams	<i>S. pneumoniae</i>	<i>N. meningitidis</i>
Penicillins	<i>S. epidermidis</i>	Enterobacteriaceae*
Cephalosporins	<i>P. aeruginosa</i>	<i>Bacteroides</i>
Monobactams	<i>E. cloacae</i>	<i>Haemophilus</i>
Carbapenems	<i>Xanthomonas</i>	<i>Enterococci</i>
Fluroquinolones	MSRA**	<i>Pseudomonads</i>
Ciprofloxacin		Enterobacteriaceae*
Ofloxacin		<i>Haemophilus</i>
Norfloxacin		<i>N. gonorrhoeae</i>
Lomefloxacin		
Aminoglycosides	Streptococci	Enterobacteriaceae*
Gentamicin	<i>Pseudomonas</i>	Streptococci
Tobramycin	Enterobacteriaceae*	
Macrolides-lincosamides	<i>Enterococci</i>	<i>S. pneumoniae</i>
Erythromycin		<i>S. pyogenes</i>
Clarithromycin		<i>S. agalactiae</i>
Azithromycin		<i>M. tuberculosis</i>
Chloramphenicol		<i>S. pneumoniae</i>
Tetracyclines	Enterobacteriaceae*	
Tetracycline	Cholera	
Doxycycline		
Minocycline		
Rifampin	MRSA**	<i>S. aureus</i>
Trimethoprim-sulfamethoxazole	Enterobacteriaceae*	<i>M. tuberculosis</i>
	<i>Neisseria</i>	<i>H. influenzae</i>
	<i>Haemophilus</i>	<i>P. cepacia</i>
Glycopeptides		<i>S. pneumoniae</i>
Vancomycin	<i>Enterococcus faecium</i>	MRSA**
Teicoplanin		MRSE**
Mupirocin		Streptococci
		Staphylococci
		Streptococci

*E.g., *E. coli*, *Klebsiella*, *Enterobacter*, *Serratia*, *Salmonella*

**For abbreviations, see text.

Letters to the Editor

A LESSON IN NEUROLOGY FROM THE HANGMAN

To the Editor:

Long before neurologists appeared on the scene, the hangman was well aware that priapism was a sure sign of fatal injury to the upper spinal cord.

Older readers will recall that when hanging was a common form of legal execution, the condemned was brought to the gallows barefooted and wore an unkempt set of trousers; there was a purpose to this....

The executioner was careful to place the hangman's knot over the central part of the upper neck so that when the condemned was

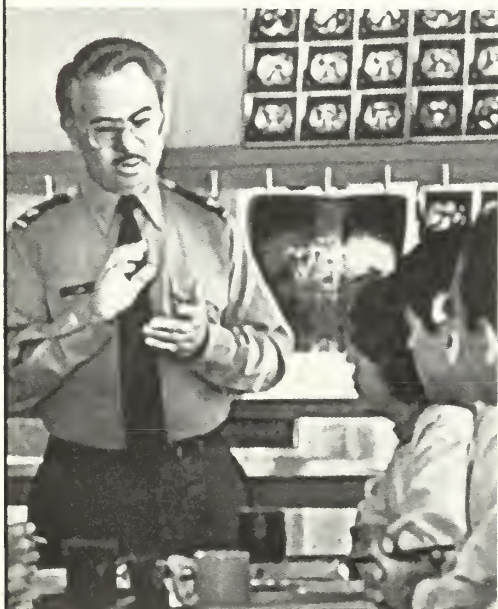
brought to a sudden stop below, the central knot snapped against the spine with great force, injuring the cervical spinal cord beneath.

Following the drop, the hangman went below, lowered the trousers and if priapism was present he knew his job was properly done.

(Sometimes persons were executed by hanging with the knot placed on the side of the neck: such people were choked to death and took several minutes to expire.)

John P. Gallagher, M. D.
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On the Cover:

ROLFE ELDRIDGE HUGHES, M. D. 1868-1933, PRESIDENT SCMA, 1929

R.E. Hughes was a Virginian, born May 5, 1868 in Columbia, VA, to E. Tucker and Nanie Perkins Hughes. He was a direct descendent of Pocahontas. He attended the University of Maryland, receiving his M. D. degree in 1892. His first practice was in Abingdon, VA, where he stayed until moving to Laurens, SC, in 1898.

In 1900 he married Hallie Cosby of VA. They had three children. Dr. Hughes was a member of the Laurens County Medical Society, the SCMA, and the Southern and Tri-State Associations. He was secretary-treasurer of the latter for 17 years until he was elected its president in 1907.

Dr. Hughes' presidential address to the SCMA in Charleston, May 8, 1929, stressed two major problems in South Carolina that he felt should be addressed by the Association. The first was the need for more beds in tuberculous sanatoria. He pointed out that even though there was a very effective treatment for TB, there had been over 1,000 deaths in

the Negro population in 1928. "The doctor is the one to meet this and he can in South Carolina. He will as he always has done, do his full duty."

The second urgent problem was the marked increase in mental diseases, many caused by pellagra "which is preventable." Dr. Hughes urges his colleagues to become more knowledgeable on diseases of the mind. "The office of the physician extends equally to the purification of the MIND and BODY. To neglect the one is to expose the other to evident peril." (Plato)

The speech concludes

Is it our duty to get more sanitaria care for the indigent tuberculous? Is it a duty of service to broaden out on Mental Hygiene? If not then the subjects can be dismissed and we can leave them to some philanthropic individual or Humane Society and organized medicine fails."

Betty Newsom

The Waring Historical Library



Alliance Page

LEADERSHIP CONFLUENCE I

Chicago's Drake Hotel was the site of the American Medical Association Alliance's 1994-1995 Leadership Confluence I, October 2-4, 1994. An enthusiastic group of presidents-elect from all across the nation were given invaluable tips and techniques for success in the upcoming year. Topics included ideas to increase and retain membership, methods of getting media coverage for alliance events, speaking with impact, and updating our leadership styles. There were also seminars concerning family violence, violence in our communities, and media effects on children. The AMAA's Strategic Planning Task Force presented its plans for the future of our national organization, while a legislative update brought attention to changes affecting all medical families. Displays feature programs of alliances and auxiliaries from each state and publications from the AMAA highlighted the Idea Fair. Time was set aside to share ideas during round table discussions and organized meal times.

South Carolinians in attendance found a small amount of free time in which to become better acquainted with each other and enjoy being together. This group included Gina Hellstrom from Anderson County, Glinda McIntyre from Richland County, Norma Bannon from Spartanburg County, Juanita Wright from Lexington County and Suzanne Rudisill from Greenville County. Our leader was Kiki Sanford, SCMAA President-elect. Everyone left the meeting with many new ideas and lots of enthusiasm to share with our local alliances and auxiliaries. Some also left with a few extra shopping bags!

Confluence II will be held January 28-31, 1995 at the Drake Hotel in Chicago. Participating from SCMAA will be Mrs. H. Woodliff Sanford (Kiki), SCMAA President-elect, Mrs. Steven Coker (Joanne) from Florence County, Mrs. Scott W. Smith (Catherine) from Greenwood County, Mrs. Brad M. Simpson (Angela) from Pickens County, Mrs. Dennis M. Clemens (Mary) and Mrs. Christopher Schroeder (Lisa) from York County. Mrs. William Hester (Betty) and Mrs. Michael Grayson (Hope) are both on the AMA Alliance board.

As submitted to Kiki Sanford, SCMAA President-elect
by Suzanne Rudisill (Mrs. L. Edwin)
President-elect, Greenville County Medical Auxiliary

Gray Matter

*"Matters of Interest
to South Carolina
Physicians."*

Thornton & Thorne give the medical community something to think about this month.

ACT QUICKLY TO ACQUIRE DISABILITY INSURANCE

Your opportunity to acquire a disability insurance policy with a guaranteed premium will be lost very soon. If you need to protect your income and are ever again going to purchase disability insurance, do it now!

For the last several months, we've written about the crisis in the disability insurance market. This month contains more of the same as announcements of sweeping changes have occurred on almost a daily basis.

Since the December issue, several more companies have downgraded occupational classifications for physicians. An occupational downgrade *increases the premium and lowers the quality of the definitions in the policy.*

The maximum monthly benefit available was substantially reduced in many companies. Health underwriting was tightened-up significantly. Benefit periods were shortened. Certain companies imposed two year benefit periods for mental or emotional claims. *Expect the companies that have not instituted these changes to do so in the immediate future.*

OPPORTUNITY STILL EXISTS

SCMA members are eligible for a 25% premium discount on disability policies issued by Connecticut Mutual. As of the day we are writing this (January 3, 1995), Connecticut Mutual will still issue its non-cancelable disability policy to physicians.

We fully expect the company to make changes to its product and issue rules. We do not know the timing nor the nature of the changes. They could come at any time.

However, until changes are announced, the opportunity remains to acquire a disability policy with a guaranteed premium and the highest quality definitions. Males and female physicians currently pay the same rates. This window may close at any moment so the time to act is very, very short.

RECOMMENDATION

We strongly recommend that you purchase as much individual, non-

cancelable insurance as you can get before Connecticut Mutual announces changes.

Once you are issued a policy, the premium cannot be changed prior to your age 65 nor can any restriction be put on the policy.

Premiums will never again be as low as they are today. Policy language will never again be as good as it is today.

If you are ever again going to acquire disability insurance, DO IT NOW!

To receive information, call our office or SCMA.

Views expressed herein are those of the authors only and in no way represent the SCMA. We do not give tax advice. Only your attorney and accountant are qualified to do so.



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INFORMATION FOR AUTHORS

The mission of *The Journal* is to advance the art and science of medicine; to promote the ideals of the South Carolina Medical Association; to encourage scholarship and good will among South Carolina physicians; and to disseminate information specifically applicable to the health care of South Carolinians. We encourage original articles and letters to the editor of potential benefit and interest to the members of the South Carolina Medical Association.

CORRESPONDENCE: All manuscripts and correspondence should be addressed to The Editor, *The Journal of the South Carolina Medical Association*, PO Box 11188, Columbia, SC 29211.

COPYRIGHT: All manuscripts should be accompanied by a transmittal letter to the editor, which should contain the following paragraph:

"This original work has not been submitted or published elsewhere, in entirety or in part. I (we) hereby transfer, assign, or otherwise convey all copyright ownership to the South Carolina Medical Association in the event that this work is published by the SCMA."

We request authors to advise the editor of any prior or anticipated duplication of their work in other publications. Submission of material as a "companion article" to material submitted elsewhere is discouraged.

PRIORITY FOR PUBLICATION: *The Journal* was founded in 1905 especially as a place for practicing physicians to publish their original observations. This purpose continues to receive priority. Growth of institutions, especially of medical school faculties, during this century may be, at least in part, responsible for a decreased tendency for practicing physicians to attempt scholarly work. Concerned about this trend, *The Journal* encourages practicing physicians to report original observations, including series of cases or individual case reports.

The Journal also welcomes timely review articles by institution-based physicians. However, it is the philosophy of the Editorial

Board that state medical journals do not represent an appropriate forum for research findings of a specialized nature. Such findings, it is felt, belong in national or regional specialty or subspecialty journals. Articles by institution-based physicians should serve the information needs of a general physician readership. Articles dealing with social, economic, and ethical issues are strongly encouraged. Historical or philosophical essays are also welcomed, although these are given lower priority compared to the above categories.

On account of both space limitations and also our desire to encourage scholarship by as many South Carolina physicians as possible, it is our policy to decline publication of more than two (2) manuscripts by one author or group of authors within any calendar year or 12-month period.

REVIEWING AND RESPONSIBILITY TO READERSHIP: We will make every effort to review manuscripts promptly. All manuscripts will be reviewed by our editorial office, and when indicated the opinions of outside consultants will be solicited.

We welcome criticisms of journal content by members of the South Carolina Medical Association.

FINANCIAL DISCLOSURE: Upon acceptance of manuscripts for publication, we require disclosure of financial interest in pharmaceutical firms or other business enterprises when such disclosure seems to be appropriate to the editor or to members of the Editorial Board.

TYPES OF ARTICLES ESPECIALLY WELCOMED FOR CONSIDERATION

1. Original scientific observations (including case reports) made by practicing physicians.
2. Concise, timely review articles (see "Priority for Publication").
3. Articles pertaining to current social, economic, and/or ethical issues affecting the practice of medicine.
4. Information uniquely pertinent to the health care of South Carolinians.

REPRINTS: These will be made available by the printer at established rates, at the time of mailing of galley proofs.

LENGTH OF ARTICLES: We prefer concise articles of approximately 2,500 words (approximately eight typewritten pages, double spaced), with no more than 10 references.

We regret that space considerations limit our ability to publish longer articles, and request that authors adhere to the above guidelines. Similarly, tables and illustrations (see below), should be kept to a minimum, and be specific and pertinent.

Authors desiring to make additional data or additional references available to readers are encouraged to do so by adding footnotes to the effect that "additional references (or tables derived from this data base, etc.) are available from the author(s) upon request."

MANUSCRIPTS: If available, these should be furnished on a 3 1/2" disk, with two typewritten hard copies. Otherwise, they should be typewritten, double-spaced, and on one side of the paper. The original and one copy should be submitted. The title page should indicate the title, author(s), author's address, and academic appointments, if any. We request that the author's name not appear on subsequent pages, to permit "blind" review of the article, when desired. Authors should retain one copy for use in proofing. Written correspondence concerning proposed (potential) manuscripts is welcomed.

ILLUSTRATIONS: These should be submitted as glossy, black and white prints no larger than a standard page; smaller prints are desired. Ordinarily, publication of four small illustrations or tables, or the equivalent, will be paid for by *The Journal*. Any number beyond this must be paid for by the author except under unusual conditions. Illustrations should not be mounted, stapled, or clipped. On the back side of each illustration, the article title, figure number, and top of figure (but not the author) should be noted lightly in pen-

cil. Legends for illustrations should be typed on a separate sheet of paper.

REFERENCES: These should be cited consecutively in the text, in superscript, e.g., "Bottsford, et al.³ ..." We recommend no more than 10 references, selected from more recent publications in accessible journals in most instances. Standard journal abbreviations should be used, with the style for journal article being as follows:

3. Bottsford JE, Bearden RC, Bottsford JG; A ten year community hospital experience with abdominal aorta aneurysms. *J SC Med Assoc* 79:57-62, 1983.

SYMPOSIUM ISSUES: We welcome proposals for special symposium issues. Guidelines for Guest Editors of symposium issues are available from *The Journal* office.

MATERIAL FOR COVER: The illustrations for the cover of *The Journal* are selected by the Curator of the Waring Historical Library, Charleston, S.C. *The Journal* welcomes suggestions and illustrations for the cover. Such suggestions should be sent to the editorial office.

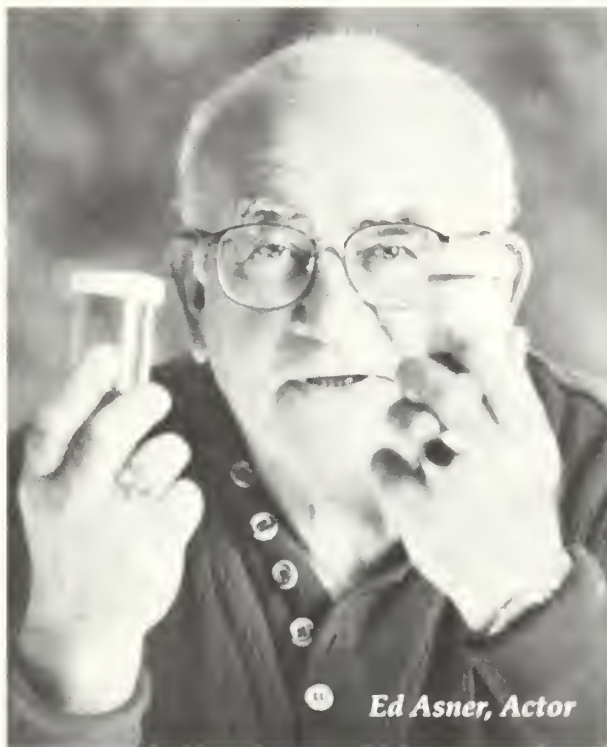
ROE FOUNDATION AWARDS

Through a gift by the Roe Foundation, a Thomas A. and Shirley W. Roe award of \$3,000 has been given each year since 1985. The award is given on alternate years to a practicing physician or to an institution-based physician.

All manuscripts submitted by South Carolina physicians will be considered for the award. Thus, manuscripts should not be submitted specifically for this award; rather they should adhere to our priorities for publication. On alternate years, all articles published during the previous two years by either practicing physicians or by institution-based physicians are reviewed and judged by our Editorial Board. The board may consult, when appropriate, with outside referees prior to rendering its decision.

Presentation of the award is made before the House of Delegates at the annual meeting of the South Carolina Medical Association.

Attention: Physicians



Ed Asner, Actor

Have your patients' medicines had a check-up?

Many of your patients take several different medicines every day. Separately each one works well. But if they take two or more different medicines in combination without checking with you to be sure they work safely together, they can sometimes be harmful...even dangerous.

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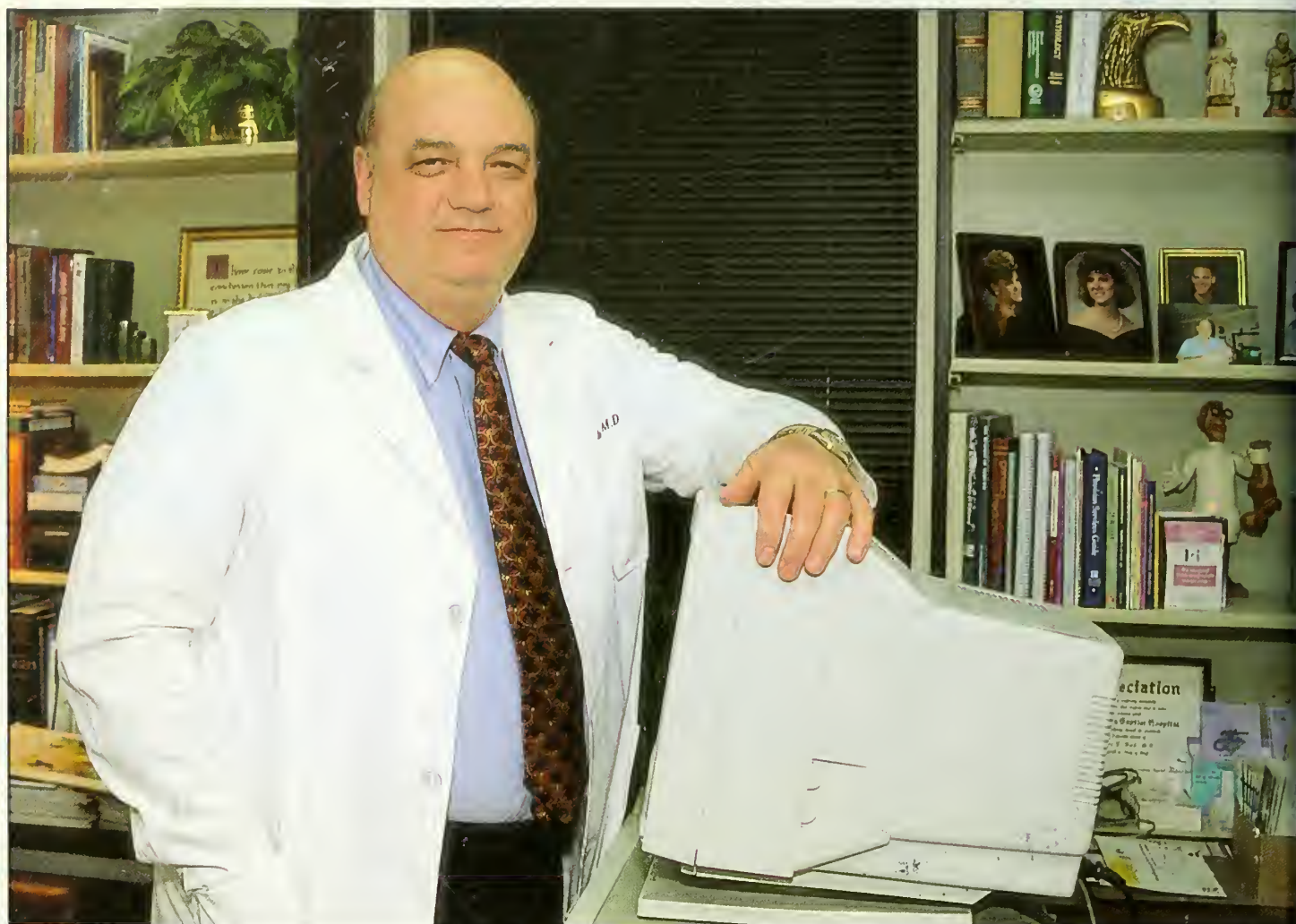
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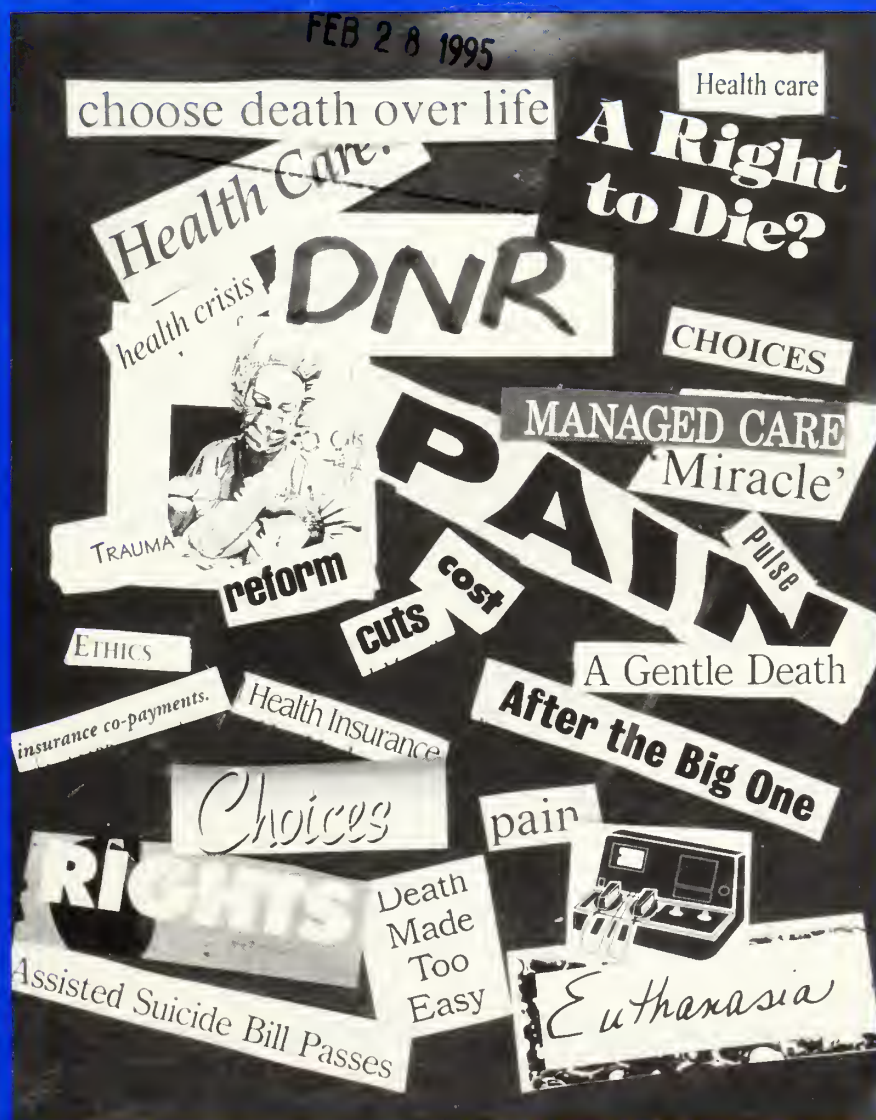


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MEDICAL ETHICS**
GUEST EDITOR: JOHN M. ROBERTS, M. D.

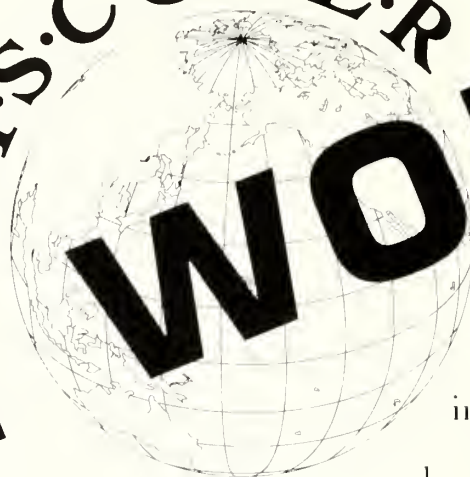
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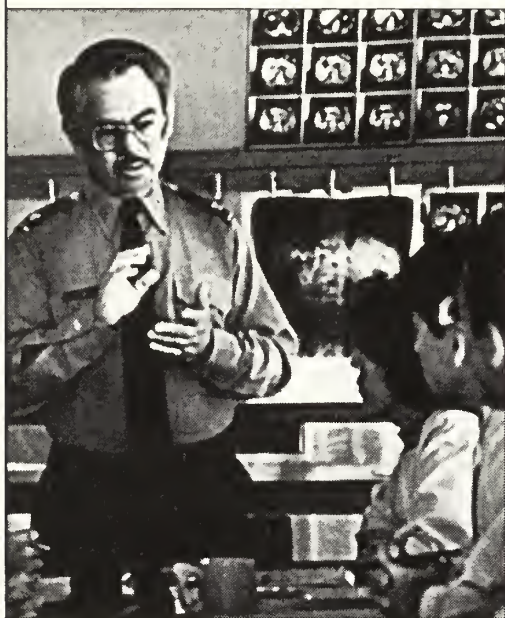
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President's Page

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THE BOTTOM LINE

There has been a flurry of reports recently regarding the financial success of managed care companies and their health-maintenance organizations (HMOs). One particular article in the *Wall Street Journal* describes these enterprises as piling up billions in cash while their managements aggressively seek new ways to park the overflowing coffers in short-term investments. The excess funds in one company alone are growing by one-half million dollars a day. In common vernacular that is "having more money than you know what to do with." A quick analysis will reveal that these managed care organizations "sell high" to the purchaser and "buy low" from the provider. Is it any wonder that their owners are growing wealthy and their stocks are the "darlings of the Street?" Rumors persist in the brokerage houses that these new growth companies will repurchase their own shares, acquire smaller insurers or buy hospitals and medical practices to compound their riches. The payors (industry, government, groups and individuals) need to be asking why the prices of their HMO premiums rose an average 10 percent in 1992, seven percent in 1993 and five percent in 1994. Doctors and hospitals need to ponder why they routinely grant fee concessions to these intermediaries that approach 35 percent of normal charges. A more fundamental question: can the United States afford to have these many dollars siphoned by contracting intermediaries into profits when millions of Americans cannot pay for basic medical services? Retained earnings do not buy diagnosis, treatment, or prevention.

Health care reform "free enterprise-style" is proceeding amok. Managed care contracts account for over 30 percent of physician income in some areas, and HMO enrollment is approaching 60 million nationwide. In some locales the managed care companies have enough market share to begin controlling the economics and delivery of medical services. Many doctors and hospitals must either provide large price concessions or risk losing patients. While some South Carolina physicians have shown great savvy in their ability to contract with managed care companies and form successful provider networks, many are only thinking, planning or worrying. Still others are in some early or formative stages of creating a provider organization.

In response to member needs, The South Carolina Medical Association has participated in the development of a Managed-Care Institute in conjunction with the Medical University of South Carolina. This is an intensive executive seminar designed around weekends to accommodate the schedules of practicing physicians. The course material is comprehensive, in-depth, and made easy for the practitioner to master. The SCMA will continue to develop resources that will help its member physicians not only survive, but thrive in this new environment so that they can continue to serve the best interests of their patients.

O. Marion Burton MD

O. Marion Burton, M. D.
President

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OF THE SOUTH CAROLINA MEDICAL ASSOCIATION

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SPECIAL ISSUE: CURRENT ISSUES IN MEDICAL ETHICS

INTRODUCTION

CHARLES R. DUNCAN, JR., M. D.*

The Medical Ethics Committee of the South Carolina Medical Association was formed in the spring of 1987. Its goal is to develop a body of useful information for South Carolina physicians about the ethical issues facing practitioners in today's health care environment. The committee addresses issues by request from the SCMA Board of Trustees, from individual members of the SCMA, from South Carolina hospitals, and from the general need for guidance on ethical issues presented by the growing complexity of our society and its impact on the health care delivery system. The committee focuses on general subjects of bioethics and medical practice and does not act on individual cases.

The committee is composed of practicing physician members of the SCMA, and is assisted by numerous consultants who have backgrounds in the academic disciplines of ethics, theology and philosophy.

We are honored to share some of our work in this special issue of *The Journal*. □

*Chair, SCMA Medical Ethics Committee, 20-A Medical Ridge Road, Greenville, SC 29605.

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BIOLOGICAL PERSPECTIVES ON THE DETERMINATION OF WHEN HUMAN LIFE BEGINS

J. RICHARD SOSNOWSKI, M. D.*

In 1950 the World Health Organization recommended the following definition: "Live birth is the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy, which after such separation breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definitive movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each product of such a birth is considered live born."

In 1972 the American College of Obstetricians and Gynecologists modified the definition to exclude from the live birth category those births in which the infant exhibits only transient heart beat or fleeting respiratory efforts.¹ And so, we have a definition of live birth. The definition pertains to human live birth. But from the biological perspective when did such human life begin?

Our first consideration must be with the process of meiosis in which one chromosome from each homologous pair is chosen for one of the daughter cells and the remaining chromosomes for the other cell. These germinal cells containing half the normal diploid complement are called haploid. In the process of fertilization two germinal cells each with a haploid content join together and produce a cell with a full diploid complement which is then in a position to undergo repeated mitosis (process of duplication followed by division). Thus the life cycle of a human being consists essentially of one meiosis followed by fertilization and a very large number of mitoses.² To give some idea of the rate of mitosis, a two-cell human conceptus

has been washed from the fallopian tube within 36 hours of conception and a 58 cell human conceptus was found in the uterine cavity within four days of conception.³

We know that in humans, fertilization occurs in the distal third of the fallopian tube. It is there that the spermatozoa and ovum meet. And it is there that syngamy occurs.³ After the ovum has been bombarded by thousands or maybe even millions of spermatozoa one penetrates the vitelline membrane, male and female pronuclei each with a haploid number of 23 chromosomes unite forming the segmentation nucleus and the diploid number of chromosomes, i.e., 46, is re-established. The entire genetic coding including the determination of genetic sex occurs at this time.⁴

Growth and development implies continuity, a steady progression of biology and behavior. The beginning of development usually is described as starting with the zygote, the single cell that results from fertilization. The concept of a pre-embryo with distinctive biologic characteristics has emerged in the discussion stimulated in part by in vitro fertilization. The preembryo can be defined as the product of gametic union from fertilization to the appearance of the embryonic axis, approximately 10 days later.⁵

We spoke a moment ago of the two-cell conceptus identified 36 hours after conception. Dr. Jerome Lejune, director of the French National Center of Scientific Research, said: "The amount of information stored in a two-cell embryo is five times greater than all the information found in the Encyclopedia Britannica. At the moment of conception all the characteristics of a new being are there.... I cannot see a difference in early human beings and a late human being because they are from the same species. Just because they grow older doesn't mean a change of species."⁶

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Following ovulation the follicle, from which the ovum erupted becomes converted to a corpus luteum. This corpus luteum produces large amounts of progesterone which prepares the endometrium for implantation.³ It is important to note that the preparation of the endometrium is for implantation not for conception, but rather for the implantation of a conceptus.

Results of recent research on hydatidiform moles and teratomas show that during pregnancy the embryo does not receive any message or information from the mother able to control the mechanisms of development or to produce the type of cellular differentiation necessary for building the tissues of the new human adult. The biological identity of the new human being does not depend on the sojourn in the uterus.⁷

Perhaps it would be helpful to quote some definitions of life. Horowitz stated that three of the properties of living organisms, mutability, self-duplication, and heterocatalysis constitute a definition of living matter. Dillon stated that life is the capability of synthesizing proteins in at least sufficient quantity to replace those that are catabolized by normal processes.⁸ It seems to me that the human conceptus formed by the union of the female and male pronuclei fulfill the criteria of these two definitions and thus can be considered a new life. Since it was the union of a human female pronucleus and a human male pronucleus, it follows that it is the beginning of a new human life.

With the above library research finished, I decided to talk to some people who teach in this area. The first was a developmental biologist at a baccalaureate college who said that rather than a specific time of the beginning of human life, there is a continuum, fertilization being simply a point in that continuum. He steadfastly refused to be pinned down to anything more definite than that.⁹ Another, although basically a toxicologist, was chairman of the department of biology at another baccalaureate college and he, too, said that life is a continuous cycle but he was willing to say that an individual life begins when the haploid sperm unites with the haploid egg.⁹ Then I began talking to our own faculty. The first was

a geneticist who said that life begins when the fetus can survive outside of the womb. He added that his Hebrew teaching was that life didn't begin until the baby was named, in case of a male, at the time of circumcision, but that his medical education had influenced him towards his former expression.⁹ A second geneticist, this one of Asian birth, said that life begins with fertilization. The entire genetic coding is in the conceptus with all the potential to be a human being. All else it needs is the proper environment in which to develop.⁹ The next was a member of our faculty who teaches embryology and he said without equivocation: "Human life begins at the time of fertilization."⁹ The last was an emeritus professor who long has taught embryology and has been respected for her research in that area and she said again without equivocation: "Human life begins when the male pronucleus and the female pronucleus unite."⁹ All of the above people had been asked the same identical question: "When does human life begin?"

In summary from all of the evidence presented previously, while brain birth may have significant legal and philosophical significance, from a purely biological perspective, I am convinced that when a human sperm penetrates the vitelline membrane of a human egg and their two pronuclei unite, forming from their haploid respective genomes the full diploid genome, then at that time a new human life has begun. □

REFERENCES

1. Danforth DN, Scott JR: *Obstetrics and Gynecology* 5th Edition, p 284-285. J. B. Lippincott Co., Philadelphia, 1986.
2. Murphy EA, Chase GA: *Principles of Genetic Counseling*, Year Book Medical Publishers, Inc., Chicago, 1975.
3. Danforth DN, Scott JR: *Obstetrics and Gynecology* 5th Edition, p 297-300, J. B. Lippincott Co., Philadelphia, 1986.
4. Willson JR, Carrington ER: *Obstetrics and Gynecology*, 8th Edition, p. 146. C. V. Mosby Company, 1987.
5. Eden RD, Boehm FH: *Assessment and Care of the Fetus*, p. 3, Appleton and Lange, Norwalk, Conn., 1990.
6. Underwood CR. Of the beginnings and endings of life. *J Med Assoc Ga*, Jan 79(12): 17-9, 1990.
7. Suarez A. Hydatidiform moles and teratomas confirm the human identity of the preimplantation embryo *J Med Philos*, Dec. 15(6):627-35, 1990.
8. Orstan A. How to define life: a hierarchical approach. *Perspect Biol Med*, Spring, 33(3):391-401, 1990.
9. Personal Communication.

THEOLOGICAL PERSPECTIVES ON THE BEGINNING AND END OF LIFE

STUART SPRAGUE, PH. D.*

ALBERT H. KELLER, S. T. M.**

The voice of theology is an interpretive voice. Just as the house of science is a place of testing hypotheses and forming theories, the house of theology is a house of interpretation. There a faith community takes all the relevant experience of its day, including scientific data, and makes meaning out of the data and other experience to guide the community's thinking, speaking and acting. What experience do we today acknowledge concerning the beginning and end of life?

We observe life to begin when the processes of metabolism and cellular definition and stability begin. Recent research in chemistry and biology has blurred any absolute point at which aggregates of molecules become living organisms. Although attempts have been made by essentialist or reductionist forms of thinking to list qualities which define life or stages of life absolutely, no such list or definition has been widely accepted by philosophers or theologians.

Human life is distinguished from other forms of life by consciousness, self-consciousness, interaction with the environment in a complex way, personhood, ability to interact with other persons through language, ability to praise God, emotions, the capacity to reason, the capacity to make meaningful choices and take responsibility for them. Neither this nor any other list of human attributes can be considered absolute. While we may talk about, experience, and celebrate human life, attempts to give absolute definitions of its character have not been widely viewed as successful.

The qualities that distinguish human life are

mediated to the individual through the cortex of the brain. Higher level brain functions make possible the richness of experience described above. When that functioning is compromised or not present, the capacity or potential for human experience appears to be diminished or absent.

From this point of view, human life begins when the qualities of human life are experienced by and through the physical body. There is no single point along a continuum at which it can be said absolutely that prior to that point humanity was absent/present and after that point humanity was present/absent. Medical science has made defining the beginning and end of human life much more complex by extending and explaining in much detail the continuum along which these changes occur.

Religious traditions have incorporated into their doctrines and ethics a variety of interpretations of personhood or human selfhood. They have been informed by a variety of theories about how flesh takes on the character of person.

The Jewish and Christian scriptures do not provide a definitive answer to the question of how or when human life begins or ends. In pre-scientific times, questions about human life and death that interest us today were simply not being asked or addressed. We hasten to affirm, however, that these same scriptures do provide a witness to important characteristics of God and humanity that have critical implications for medical practice today.

From the evidence of the Bible, we interpret God as the creator and continual source of life, God as one who cares deeply for all of life, God as having shared an image and fellowship with human beings, God as intending shalom and justice for all creation, God as judge, God as redeemer, and God as source of hope for

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ultimate meaning in life. From the evidence of the Bible we believe that all of life is blessed and valued by God. This gives us a bias, in reference to beginning and end of life decisions, in favor of preserving and protecting life where possible. There should also be a presumption in favor of justice in sharing the resources available to preserve life among all God's people.

Theological traditions that derive from Biblical interpretation also hold basic understandings of the nature of humanity. The living human being is a whole and unitary being, which means that the human being is indivisible into parts (such as body, soul, or mind) without ceasing to be a living human being. This biblical view sees the individual as an ensouled (personalized) body or an embodied soul. The individual is called into human life by active response to God and to other people in community.

This unitary view of the living human being also has direct implication for medical decisions, particularly those at the end of life. The biopsychosocial unity of the human being is dissolved or comes to an end when the brain irrevocably ceases to provide the physiological basis for consciousness, which makes responsiveness, mutuality, mentation, feeling, and decision possible. To say it another way, when the unique, essential unity of the human is lost, mere biological vitality does not qualify the individual as an active member of the human community. Death has occurred: the living human being has returned to dust.

An important corollary to these two ideas is the affirmation that physical life is not sacro-

sanct. Many religious traditions disavow idolatry. Idolatry can be defined as the worship of any thing or person other than God. Only God is sacred. Elevation of anything other than God to the same position occupied by God moves one toward idolatry. For example, if physical life were sacred, one ought not to sacrifice it, even for a great cause. If physical life were sacred, then it ought to be preserved at all costs. Dying ceases to be a human experience attended by courage and care, becoming instead an absolute evil. That notion is opposed by religious traditions that worship God instead of mortal life.

The theological perspective outlined here acknowledges that decisions affecting the beginning and end of life are among the most difficult moral issues of our day. On the one hand we affirm the high value of human life and the imperative to support it with skill and with equity. On the other hand, we affirm the integrity or wholeness of human life, such that when it ceases to exist, the individual is no longer a living human being. These affirmations give a shape to our moral response to specific issues at the edges of life, as we continue to explore with colleagues difficult questions for which no absolute answers exist. □

BIBLIOGRAPHY

1. Cobb, JB, Jr. *Matters of Life and Death*. Louisville: Westminster/John Knox, 1991.
2. Davis, DS. Abortion in Jewish thought: A study in casuistry. *Journal of the American Academy of Religion* 60: 313-324, 1992.
3. Hick, John. *Death and Eternal Life*. San Francisco: Harper & Row, 1976.

DEVELOPING POLICIES ON DO-NOT-RESUSCITATE ORDERS: LEGAL, ETHICAL, AND CLINICAL ISSUES*

STEPHEN P. WILLIAMS, J. D.

JOHN M. ROBERTS, M. D.**

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BACKGROUND

Do-not-resuscitate (DNR) orders have become an issue of increasing concern to physicians, nurses, and hospital administrators since passage of the federal "Patient Self-Determination Act" in 1991 and several South Carolina laws concerning decisions at the end of life.

In the fall of 1993, the Medical Ethics Committee of the South Carolina Medical Association developed a position addressing some of the ethical issues related to DNR orders. It also produced a statement on futile and ineffective treatment, an issue closely related to DNR orders. The SCMA Board of Trustees approved both statements and invited the South Carolina Hospital Association to form a joint committee to study the feasibility of developing positions approved by both associations which would advise hospitals and their clinical staffs in designing and implementing procedures and policies concerning DNR orders and futile care.

The SCMA-SCHA Joint Committee on Futile Care and DNR Orders was appointed and met during the summer and fall of 1994 to discuss these issues from ethical, legal and clinical perspectives. Its conclusions regarding futile care are contained in the companion article which follows, "Medical Futility and Ineffective Care: A Proposal for Hospital Policy."

In its considerations of DNR orders, the joint committee noted a prevalent belief in the health

care community that both custom and fear of legal action have led to routine resuscitation after cardiopulmonary arrest, even when a patient had virtually no chance of survival. To help reduce the number of such instances, the committee believed that guidance on the issues of DNR procedures would be useful to the health care community.

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UNDERLYING PRINCIPLES

The Joint Committee concluded that the ethical tenets of beneficence and respect for autonomy are paramount principles. Beneficence means doing that which is good, and in the health care context means acting in a manner in which the patient or surrogate has requested them to act and in providing care which will prove beneficial to the patient. Respect for the patient's autonomy requires that, after becoming informed, the patient or surrogate be allowed to accept or refuse beneficial care.

The ethical principle of respect for autonomy underlies the legal doctrine of informed consent. DNR orders may be based on a corollary to informed consent: informed refusal. The law presumes that a patient or surrogate agreeing to a DNR order has discussed treatment options with medical professionals and, after consideration of the alternatives, has requested not to be resuscitated in case of cardiopulmonary arrest.

DNR orders may also be based on futility. Caregivers are under no obligation to provide resuscitation in a futile situation (see following document on futile care). In such cases, the physician should notify the patient or surrogate of the DNR order whenever possible. Hospital administrators and clinical staff should carefully review the following document, "Medical Futility and Ineffective Care: A Proposal for Hospital Policy," as a guide to defining what futile care means, and should consider instituting a policy concerning such treatment. Such a policy may be particularly helpful when the medical and nursing staffs are requested by family members of non-communicative patients to provide care which is not medically indicated or beneficial to the patient, or when family members disagree about proposed courses of treatment. Clinical staff and administrators should familiarize themselves with current South Carolina law such as the "Adult Health Care Consent Act" which may provide additional guidance and legal protection to physicians, nurses, and the hospital.

Virtually all South Carolina hospitals currently have in place a policy governing DNR orders in compliance with accreditation standards of

the Joint Commission on Accreditation of Healthcare Organizations, state law, clinical procedural requirements, and in some instances, ethical concerns. These policies differ substantially, though they share many similarities.

RECOMMENDATIONS

The joint committee makes the following recommendations for consideration by hospitals, appropriate departments, and medical staffs in formulating or reviewing DNR policies.

1. Discussion of resuscitation preferences may take place either with every patient upon admission or with selected patients as dictated by medical condition. Ideally, this discussion should occur between the attending physician and the patient or surrogate.
2. Some South Carolina hospitals currently use a form which prompts patients at the time of admission to discuss their views about resuscitation with the medical or nursing staff. An example of such a form is *Discussing the Hospital's Life Support Policy*. Determination of the utility of such a form should be based on each hospital's unique circumstances.
3. In developing or reviewing DNR policies, hospitals and their clinical staffs should clearly define what "resuscitation" and "resuscitative measures" mean.
4. A DNR policy should avoid any presumptions about what a patient's wishes are; they are not uniform and are frequently different from what physicians and nurses believe them to be. A special difficulty arises when a patient not under a DNR order suffers cardiopulmonary arrest, is successfully resuscitated, and later arrests again. The policy should ensure that such patients or surrogates be afforded an opportunity to discuss with the attending physician what their desires are concerning future resuscitation.
5. Whether or not DNR orders should be reconsidered and rediscussed with the patient or surrogate before operative procedures should also be addressed by the policy. Many hospitals temporarily suspend DNR orders at the time of operations

because of the special circumstances necessitating surgical interventions and the transient risks of operations. The status of DNR orders during operations should be considered in developing a policy. If such orders are suspended, the patient or surrogate should be informed and should consent to the change.

CONCLUSION

The Joint Committee respects and values the diversity of hospital facilities and clinical staffs throughout the state. This discussion attempts to provide a broad backdrop against which individual hospitals can craft or revise their own policies. The joint committee has purpose-

ly avoided providing standard forms for DNR orders, preferring to guide rather than to standardize. Hospitals or clinical staffs desiring specific guidance in designing policies or order forms can obtain a packet of examples collected from South Carolina hospitals by contacting the South Carolina Hospital Association.

All policies and procedures concerning both DNR orders and futile care issues have legal as well as policy implications. Each hospital's legal advisors should review their own methods of dealing with these issues. Note also that DNR policies are often referenced in other clinical protocols and procedures. When any changes are made, all policies should be reviewed to assure internal consistency. □



SCMA NEWSLETTER

A PUBLICATION OF THE SOUTH CAROLINA MEDICAL ASSOCIATION
Joy Drennen, Editor
798-6207, in Columbia

Contributions welcomed
1-800-327-1021, outside Columbia

February 1995

HIGHLIGHTS OF THE JANUARY BOARD OF TRUSTEES MEETING

The SCMA Board of Trustees heard a staff report on a proposal to form a coalition of other private and public agencies to compile reference information and resources available regarding family violence. The information will apply to child abuse, spousal abuse, elder abuse and other domestic violence issues. The compiled information will be published into a single compendium with county-by-county references, and will be distributed to physicians, law enforcement personnel, churches, teachers, and oth-

ers. The board endorsed the proposal and staff has begun developing the project.

The board also continued to study the issue of "any willing provider" legislation. A draft statute was presented to the board in response to last year's House of Delegates mandate that such legislation be prepared. The board voted to send this model to the 1995 House of Delegates for approval. □

MEDICARE UPDATE

Included in the February, 1995 Medicare Advisory is complete information regarding Security Act (42 U.S.C. Section 1395 nn) which prohibits certain self-referrals within the context of Medicare and Medicaid programs. Please read this article carefully. Pending the publication of final regulations, Medicare will enforce the law based on the language of the statute. Each month, the *Medicare Advisory* is full of information and should be read carefully.

E/M Workshops: In order to help you understand the implications of the new guidelines for documentation and coding, Medicare is conducting workshops during the month of March. The registration fee for physicians is waived, and physicians are encouraged to attend. Registration forms and specific workshop dates and locations are in the February *Advisory*.

Medigap Crossover Claims: The Medigap crossover process eliminates the need for beneficiaries or participating providers to file separate claims to Medigap insurers. Your Medicare remittance will contain an indicator which will identify each Medicare claim that Palmetto GBA has forwarded to a Medigap insurer. To ensure that Palmetto GBA has the necessary information to effect this Medigap crossover, you should adhere to the claims filing instructions that are in the February, 1995 *Medicare Advisory*. This information must be completed to ensure automatic crossover claims to Medigap insurers. If the required information is missing or incomplete, no transfer of claim information will occur.

Interest Rate Update: The interest rate for overpayments and underpayments is 13.375 percent effective January 6, 1995. This interest rate is applied to the amount due from a provider when a claim has been overpaid, and underpaid by Medicare when additional benefits resulting from an appeal or hearing are not paid within 30 days of determination.

Specialty Workshops: Complete information and registration forms are included in the February *Medicare Advisory*. The cost will be \$20 per person. General/Family Practice will be held 9:30 am-12:30 pm, and non-physician practitioners will be held 2:30-4:30 pm. Dates and locations will be: Greenville, March 9, 1995; Charleston, March 10, 1995; Myrtle Beach, March 22, 1995; Spartanburg, March 23, 1995; Columbia, March 27, 1995; and Florence, March 30, 1995.

Physician Retainer Agreements: HCFA has been advised that some physicians have asked their patients to sign retainer agreements in which the physician agrees to accept assignment, pay the Part B deductible and/or coinsurance and provide certain Medicare noncovered services (such as an annual physical exam) for a monthly or annual premium. In a July, 1994 memorandum, HCFA advised state insurance commissioners that physician retainer agreements are insurance and may violate the federal law. HCFA has instructed Medicare to report any physicians using retainer agreements to the SC Department of Insurance for investigation. □

CLIA Activation: Effective March 1, 1995, regardless of the date of service, the Finance Commission will edit all non-physician and independent lab claims for CLIA compliance. The type of CLIA certification, certification date and CLIA number on our Medicaid provider file must match the laboratory services billed or the claim/lines(s) will reject. The descriptions and resolutions of the new CLIA error codes will be available in a forthcoming bulletin. **Note:** The Finance Commission does not require submission of your CLIA number on each claim.

TPL Update: The Finance Commission has recognized a problem with the automatic transmission of claims from Medicare to third party payors (if applicable) and Medicaid. Some providers are receiving payment from Medicaid and other third party payors which is resulting in an overpayment in many instances. This concern is cur-

rently being investigated and possible solutions are being considered.

CPT Code Update: Effective with dates of service on or after January 1, 1995, either the old or the new 1995 CPT procedure codes may be billed until March 31, 1995. Effective with dates of service on or after April 1, 1995, only the 1995 CPT procedure codes will be accepted.

Indian Health Services (IHS): American Indians may be eligible for Medicaid if they meet program requirements for the appropriate coverage group. The Public Health Regulations at 42 CFR 36.61 specifically lists Medicaid as an "alternate resource" that must be used prior to IHS payment. Therefore, when an American Indian is Medicaid eligible and is covered under the IHS program, Medicaid **must** be billed as the primary insurer. ☐

MEDICARE CAMPAIGN

The SCMA and the American Medical Association (AMA) called on President Clinton and Congress last month not to "place an artificial cap on Medicare expenditures in the name of political expediency."

In a letter signed by the SCMA, AMA and other state medical societies, the organizations warned Congress and the President that Medicare is "headed toward a major financial crisis" without major, lasting reform. Although physician payments under Medicare account for 23 percent of program spending, the groups noted, physicians have been asked to absorb 40 percent of all Medicare program cuts over the past 12 years. ☐

147th SCMA ANNUAL MEETING Omni Hotel, Charleston, SC April 20-23, 1995

Earlier this month, you should have received an informational brochure, including hotel and registration forms, for the 147th Annual Meeting and Scientific Assembly. Please complete and return your registration to SCMA Headquarters early to avoid waiting in line to register at the meeting. In addition to business and social activities, up to 15 AMA CME Category 1 credit hours toward the AMA Physician Recognition Award can be earned.

If you did not receive your brochure and registration information, please call SCMA Headquarters at (803) 798-6207 in Columbia, or 1-800-327-1021 statewide. ☐

SC MANAGED CARE INSTITUTE

The SCMA is sponsoring the SC Managed Care Institute which will be presented by the MUSC Department of Health Administration and Policy on March 17-19 and April 7-9, 1995 at the Omni Hotel in Charleston. The purpose of the Managed Care Institute is to provide an intensive educational opportunity for physicians in SC. The Institute will have as its primary focus managed care and physician practice within a managed care context. It is anticipated that every participant in the Institute will become knowledgeable about not only the development of managed care in America but also organizational, financing, policy, legal and professional practice issues.

At the conclusion of the Managed Care Institute, the participants should be able to (1) list and define the basic principles of managed care; (2) analyze the basic processes of managed care; (3) outline the possible future developments in managed care; and (4) apply professional development within a managed care framework. Physicians must attend both sessions.

There are only 50 slots available. *If you are interested, please contact Elizabeth Biggers at (803) 798-6207, ext. 236 or (800) 327-1021, ext. 236.*

PHYSICIANS CARE NETWORK UPDATE

Effective February 1, Fennel Container Company, Inc., a total waste management service, will begin offering PCN as a health care option. Fennel is the largest independently owned hauler in South Carolina with offices in Charleston and Greenville. Employee Resource Management will become effective March 1. Employee Resource Management is a statewide employee leasing company, which was chosen as the SC Emerging Entrepreneur of the Year for 1994. The Entrepreneur of the Year Program was founded by Ernst and Young and co-sponsored nationally by *INC. Magazine* and Merrill Lynch.

Two more hospitals have contracted with the Physicians Care Network: Health South Rehabilitation Hospital in Columbia, and Wallace Thomson Hospital in Union. This brings the total number of hospitals contracting with PCN to 37. Approximately 2,700 physicians have enrolled in PCN to date.

ASK THE EXPERTS: HOW DO YOU RATE?

Employers and health plans are demanding ever more data from physicians, asking that they prove their efficiency and proficiency with treatment checklists and outcomes measurements. But does anyone ask the best judges—your patients—what they think?

The sample survey on the following page of this newsletter can help physicians see how they are perceived in the eyes of patients. A staff member can compile responses to show to health plans or help guide physicians in ways to improve the practice. Feel free to photocopy the page or reproduce the survey on your stationery.



PALMETTO HEALTH INITIATIVE HOTLINE

Question: *Who determines which physician the Medicaid patient will go to?*
(N. Bennett, MD)

Answer: The Medicaid patients will choose one of two managed care plans: (1) Capitated Access Program (CAP), a fully capitated program covering most Medicaid services which allows the Medicaid recipient to enroll in an HMO, and (2) Physicians' Enhanced Program (PEP), a partially capitated program covering primary care services which allows the Medicaid recipient to choose one physician to serve as a "gatekeeper."

Under both programs, the recipient will choose his or her physician from a list of participating physicians. However, if the recipient refuses to choose a physician, he/she will be auto-assigned. This system of auto-assign is still being developed by the Health and Human Services Finance Commission, the state agency responsible for administering the state's Medicaid program.

The Finance Commission plans to contract with a Member Access and Choice Coordinator (MACC) who will be responsible for determining that the person is eligible for the program, enrolling the recipient in the plan of his/her choice, and following through with the auto-assign if necessary.

Please call the Palmetto Health Initiative Hotline (1-800-825-7821) with your questions regarding the Medicaid waiver.



SCMA MODEL PATIENT SATISFACTION SURVEY

Dear Ms. or Mr. _____:

It is [my/our] objective to provide you with quality medical care in a courteous, professional manner that makes you feel both comfortable and confident that you are getting quality care. Please let us know how you would rate [name of doctor or group] using the specified scale. (Circle the rating on the scale that applies.) Questions 13 and 14 are optional.

1. Convenience of our office location

1	2	3	4
EXCELLENT	GOOD	FAIR	POOR

2. Hours when our office is open

1	2	3	4
EXCELLENT	GOOD	FAIR	POOR

3. Attractiveness and cleanliness of office

1	2	3	4
EXCELLENT	GOOD	FAIR	POOR

4. Referrals to specialty care or other practitioners when necessary

1	2	3	4
EXCELLENT	GOOD	FAIR	POOR

5. Ability to see [me/us] in an emergency

1	2	3	4
EXCELLENT	GOOD	FAIR	POOR

6. Convenience of making appointments by phone

1	2	3	4
EXCELLENT	GOOD	FAIR	POOR

7. Length of time spent waiting at the office to see the doctor or other practitioner

1	2	3
SHORT/NO WAIT	AVERAGE WAIT	TOO LONG

8. Length of time waiting between making an appointment and the day of your visit

1	2	3
SHORT/NO WAIT	AVERAGE WAIT	TOO LONG

9. Availability of medical information or advice by phone

1	2	3	4
EXCELLENT	GOOD	FAIR	POOR

10. Do we communicate medical issues and procedures clearly?

1	2	3	4
EXCELLENT	GOOD	FAIR	POOR

11. Attention given to what you have to say

1	2	3	4
EXCELLENT	GOOD	FAIR	POOR

12. Advice we give about ways to avoid illness and stay healthy

1	2	3	4
EXCELLENT	GOOD	FAIR	POOR

13. Number of doctors you have to choose from

1	2	3	4
EXCELLENT	GOOD	FAIR	POOR

14. Ease of seeing the doctor of your choice

1	2	3	4
EXCELLENT	GOOD	FAIR	POOR

15. Friendliness and courtesy shown to you by doctors

1	2	3	4
EXCELLENT	GOOD	FAIR	POOR

16. Friendliness and courtesy shown to you by staff

1	2	3	4
EXCELLENT	GOOD	FAIR	POOR

17. Attention to your privacy

1	2	3	4
EXCELLENT	GOOD	FAIR	POOR

18. Reassurance and support offered to you by doctors and staff

1	2	3	4
EXCELLENT	GOOD	FAIR	POOR

19. Amount of time you have with doctors and staff during a visit

1	2	3
LOTS	SUFFICIENT	NOT NEARLY ENOUGH

20. Overall quality of care and services

1	2	3	4
EXCELLENT	GOOD	FAIR	POOR

21. Would you recommend [us/me] to your family or friends if they needed care?

1	2	3
YES	NO	MAYBE

Thank you for your time.
Please return this survey in the enclosed, self-addressed, stamped envelope.

Name of person who filled out survey (optional)

MEDICAL FUTILITY AND INEFFECTIVE CARE: A PROPOSAL FOR HOSPITAL POLICY*

ROBERT M. SADE, M. D.**

PURPOSE

Treatment may be withheld or withdrawn for many reasons. The most common reason is refusal by the patient of a proffered treatment; such refusal, under the ethical and legal principle of respect for individual autonomy, justifies and requires discontinuation of specific therapies. Another reason for withholding treatment is futility.

In some medical situations, treatment is so unlikely to result in a salutary outcome that the care may be deemed "futile." The notion of futile treatment, though, contains two components: the personal values of the patient and the effectiveness of the treatment. Out of respect for autonomy, doctors and hospitals should not substitute their own values for those of the patient. They have no obligation, however, to provide treatments that are ineffective in achieving defined goals; ineffective treatments may therefore properly be withheld or discontinued.

In most situations when the question of futility arises, an appropriate outcome is, and should be, achieved through discussions between the physician (with other care-givers) and the patient or surrogate. On rare occasions, though, a satisfactory solution cannot be reached between them. This policy is intended to provide guidance when there is such disagreement.

A treatment is futile either when the patient chooses to forego it because of insufficient benefit, or when the treatment cannot achieve objective therapeutic goals. Under this policy, determination of futility is not based on the subjective component, the patient's values and preferences. Its determination rests solely on the objective component of futility, ineffectiveness.

POLICY

The minimal expected outcome of treatment for each patient is survival with consciousness.¹ When treatment has been determined to be ineffective in achieving that outcome, it should be discontinued.

PROCEDURE

1. A treatment that has virtually no chance of leading to survival with consciousness is deemed to be ineffective (a rare "miracle" cure does not establish effectiveness of treatment).
2. A physician who determines that one of his patients has virtually no chance of survival with consciousness must document this in the hospital record.
3. After this determination is made, all treatment except comfort care should be discontinued.
4. This determination can be overruled by showing objectively that the supporting data are incorrect, or by documenting a reasonable probability that a new therapy clearly renders the available information inapplicable.

COMMENT

Advancing technology has made it possible to keep patients alive longer under circumstances they would not have survived in an earlier era. This has led increasingly to what could be characterized as misuse of technology: acceding to demands by severely ill patients or their surrogates for care that many believe is futile. Similarly, some care-givers, through heroic efforts to do everything possible for their patients, may provide care that is futile.

The notion of futility in health care has been widely discussed, but important difficulties arise from vague and inconsistent uses of this word. "Futile" care has been generally defined

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as care that is of little or no benefit to the patient. It has been argued that resources should not be used for medical interventions that are futile.² Confusion results when futility is understood in terms both of benefit, which has an important subjective component, and of effectiveness, which describes measurable outcome.³ Indeed, a cogent argument has been made that the concept of futility is not useful except in narrowly defined cases of ineffective treatment.⁴

Clear definition of terms is therefore crucial. For purposes of this document, "beneficial" treatment is defined as effective therapy that the patient values sufficiently to pay the psychological, physiological, and other personal costs imposed by the treatment. The object of benefit is the whole person, not merely an organ system or physiological process. The concept of benefit includes both physiological effectiveness and value judgments. Because values, such as life, quality of life, pain, mental capacity, and others are weighed differently by every person, questions of degrees of benefit can be answered, ultimately, only by the beneficiary, the patient.

Effective treatment, on the other hand, can be defined in terms of objective outcomes. Treatment that is known not to be able to achieve a specified goal we define as "ineffective." Effectiveness is distinct from benefit; effective treatment may or may not be beneficial. For example, treating pneumococcal pneumonia with penicillin may well be effective in clearing a lung infection, but it may not be beneficial to a patient who is terminally ill with cancer. In addition, it is important not to require certainty that a treatment will not work before calling it ineffective, because apparently miraculous exceptions can be found to almost any claim of ineffectiveness; there is no absolute certainty in the art and science of prognosis.

There is no moral or legal obligation for a physician to provide care that is ineffective.⁵ Professional integrity demands that patients not be subjected to ineffective care, even if requested, but that they be educated regarding effective alternatives, if any. Similarly, a hospital is

not bound to provide care that is ineffective, but to provide an environment that supports health professionals in effectively caring for their patients. The definitions above provide a means to identify at least some situations in which there is no obligation to initiate or continue treatment. Limiting care on grounds of ineffectiveness is a positive responsibility of physicians and hospitals. The idea of futility is useful in discussions between patients and health care givers, but limiting care on grounds of an undifferentiated notion of futility that is laden with value judgments and norms of medical practice requires a higher degree of social consensus than we now have regarding health and medical values.

Ineffective care should be withheld, or stopped if already begun. Some care-givers are more reluctant to withdraw than to initially withhold ineffective treatment; however, stopping treatment is generally held to be morally the same as withholding it initially. Medical facts and conditions inevitably change during treatment, and a therapy that was effective when it was begun may become ineffective. The decision-making process should be based on the circumstances at the time decisions must be made, not on conditions that existed at a prior time. Moreover, concerns of the legality of withdrawing treatment are not well founded; though there may be difficulties related to the legal notion of abandonment if effective treatment is withdrawn, there is nothing in the law that forbids or distinguishes between withholding and withdrawing ineffective treatment. The reluctance of some care-givers to withdraw ineffective treatment, while understandable, often is based mainly on emotional rather than on moral or legal grounds.

These considerations lead us to propose the policy described above. A policy regarding ineffective care could be useful, when modified for specific settings, to physicians, hospitals, nursing homes, and other care-givers.

An important limitation of this proposal is that the data required to make the determinations suggested are currently available in only a few special instances. The adoption of policies

like this may have the propitious effect of stimulating physicians, epidemiologists, and others to generate such objective data over a broad range of medical care. □

ENDNOTES

1. South Carolina law provides a definition of permanent unconsciousness: "Permanent unconsciousness means a medical diagnosis, consistent with accepted standards of medical practice, that a person is in a persistent vegetative state or some other irreversible condition in which the person has no neocortical functioning, but only involuntary vegetative or primitive reflex functions controlled by the brain stem." (S.C.Code Ann. § 44-77-20[7][Cum. Supp. 1992]) It further states: "A certification based upon a diagnosis of permanent unconsciousness may not be made until the declarant has remained unconscious for at least ninety consecutive days, or at any time if the declarant has experienced massive destruction or atrophy of the cortex as evidenced by neurodiagnostic studies or gross inspection of the brain, or some other characteristic of the declarant's condition allows a diagnosis of permanent unconsciousness to be made with a high degree of medical certainty." (S.C.Code Ann. § 44-77-30)[Cum. Supp. 1992])
2. The case of Helga Wanglie is an example of inappropriate use of resources in the face of futility, and illustrates some of the complexities at the interface of law with health care. See Miles SH: The case of Helga Wanglie; A new kind of "right to die case." *New Engl J Med* 1991;325:511-515.
3. A discussion that describes the confusion in the use of this terminology can be found in L.J. Schneiderman and coauthors' clarification of definitions (Medical futility: its meaning and ethical implications. *Ann Int Med* 1990;112:949-54). We are indebted to the same group for the suggestion of using objective criteria for defining the limits of futility (Schneiderman LJ and Jecker NS: Futility in practice. *Ann Int Med* 1994; in press).
4. Truog RD, Brett AS, Frader I: The problem with futility. *New Engl J Med* 1992; 326:1560-3.
5. This issue is thoroughly discussed by J. J. Paris and his coauthors (Physicians' refusal of requested treatment: the case of Baby L. *New Engl J Med* 1990; 322:1012-5; Beyond autonomy—physicians' refusal to use life-prolonging extracorporeal membrane oxygenation. *New Engl J Med* 1993; 329:3547). They argue on moral and normative grounds that patients are free to reject a physician's recommended treatment, but they are not free to design their own treatment, and the physician is not obligated to provide it. They cite a series of legal decisions and philosophic arguments that support this view.

IMPLICATIONS OF MANAGED CARE FOR MEDICAL ETHICS*

ROBERT M. SADE, M. D.**

MARY FAITH MARSHALL, PH. D.

JOHN M. ROBERTS, M. D.

DOUGLAS MACDONALD, PH. D.

INTRODUCTION

Physicians have always "managed care" of their patients by recommending appropriate diagnostic tests and treatment, referring patients to consultants or specialists, and coordinating most aspects of care. Contemporary use of the term "managed care," however, refers to procedures and systems used by third party payers, both private and government, to control payment and affect access to health care services. Managed care has already substantially affected the practices of most South Carolina physicians, and promises to become even more prominent under many of the proposals for national reform of health services financing.

This statement is a commentary on our changing professional relations, as well as an attempt to clarify ethical obligations in the evolving professional environment. Our purpose is not to judge managed care: it is now a fact of professional life, and its prevalence is increasing. Rather, our purpose is to examine the ways in which the professional relations of physicians are affected by managed care.

The introduction of new and nontraditional techniques to control finances and services has produced uncertainty in many physicians about their ethical obligations to their patients, to colleagues, to third parties, and to society. Moreover, many physicians express decreasing levels of satisfaction with their work, at least in part because of perceived loss of professional autonomy imposed by managed care.

PROFESSIONAL WORK

The motivations of physicians in choosing

medicine as a career and in sustaining professional life are many. They include the rewards of service to others, the opportunity to seek new knowledge continually and apply it in clinical service, virtual assurance of more or less economic success, enjoyment of the power to help others through superior knowledge, and the rewards of prestige and status accorded physicians in our society. These motivations are present in varying mixtures in each of us, and for each of us, the proportions change at different stages of our careers. If economic success, power, and prestige are major sustaining factors, the vagaries of managed care and health services reform may toss us about unpredictably; then, the practice of medicine could become mere labor, with little of the satisfaction of earlier years. If, on the other hand, the opportunity to serve and the rewards of lifelong learning are the most important professional rewards, medicine can continue to be exciting and satisfying under almost any system of health system reform.

THE PHYSICIAN AS FIDUCIARY TO THE PATIENT

Holding the best interest of the patient as the first priority of professional life has long been part of medical ethics, and is explicitly stated in the SCMA code of ethics.¹ This principle has led to such statements as: "Physicians are required to do everything they believe may benefit each patient without regard to costs or other societal considerations,"² and "Asking physicians to be cost-conscious...would be asking them to abandon their central commitment to their patients."³

These views arise from the Hippocratic tradition of beneficence and from the belief that physicians owe special obligations to patients because patients, *qua* patients, are vulnerable.

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Their vulnerability arises from the association of illness with compromise of clear thinking that may distort the patient's ordinary judgment, as well as from important differences in medical knowledge that weigh the balance of power in favor of the physician's side of the relationship. The special obligations of physicians, not owed under general contractual circumstances, comprise a fiduciary, or trust, relationship, manifested as fidelity to the patient's best interest.

Ordinary business ethics do not apply to the physician-patient relationship. The patient's vulnerability requires a fiduciary commitment on the part of the physician to serve a patient's medical interests above his own financial interests. This commitment is realized on two levels, individual and social. First, the physician must place his patient's interests above his own. Second, the physician must place his patient's interests above those of all others, including the interests of business, government, and society.⁴

This commitment was more easily realized in the past, when retrospective reimbursement and cost-shifting allowed for a unitary approach to the delivery of health care. Recent trends in reimbursement, including capitation and managed care plans, raise important questions. How does a physician maintain fidelity to a patient under these circumstances? Does he have new responsibilities to all patients in a health plan⁵ or to everyone in society, given resource limitations? What obligations does the physician owe to the plan versus the patient?

The advent of managed care has produced potential challenges to the traditional fidelity of physicians to patients in the context of limits to care imposed against the patient's good in favor of the good of society, the good of the health plan, and the good of the physician. Haavi Morreim has offered a proposal to clarify some of those boundaries: a divided standard of care.⁶ Physicians are held to a **standard of medical expertise**, which is "the level of knowledge, skill, and effort that he is expected to deliver to every patient whom he accepts for care, regardless of the patient's income." A second standard, the **standard of resource use**, "is the level of medical and monetary resources to which the patient is legally entitled...[which] is a function, not of what some physician thinks he needs, but of what care or coverage the

patient or others have purchased for him." Someone other than the physician is thus cast in the role of rationer. This division of standards should be recognized in medical ethics, by society, and in the law.

The limits to care set by society or by a health plan are likely to be ambiguous, however, so the divided standard offers little guidance to the physician in deciding whether to be an advocate for the patient for particular interventions. Treatment options that are not beneficial to the patient need not be presented to the patient nor should they be advocated by the physician.⁷ But what of beneficial interventions? What are the physician's obligations when a beneficial treatment is excluded by the plan? Susan Wolf has suggested an algorithm to guide the physician in informing patients and advocating on the patient's behalf, based on whether or not the plan excludes a potentially beneficial treatment, or whether the plan gives the physician discretion in limiting care.⁸ Under her algorithms, the physician is always obligated to **inform** patients of potentially beneficial treatment. The obligation to be the patient's **advocate** for a specific beneficial service may vary, however. We propose a modification of her algorithm to reflect advocacy obligations under varying degrees of benefit and plan designs. (Figure 1).

Fidelity to the patient's interests extend to interprofessional relations as well. Health plans often require that consultations be sought only from specified physicians. Not all physicians are of equal ability, ranging along a spectrum from outstanding to incompetent. There are long established procedures for dealing with questions of competence, and these are not altered by managed care.⁹ Not many physicians are located at the lower end of the spectrum, but there are some, and those few may have the formal credentials to be included on a plan's approved consultant list. If a physician has reason to doubt the competence of another physician to whom referral is mandated by the plan, his obligation to the patient requires that he not make such a referral. Health plans should have alternate referral options to anticipate and accommodate such contingencies.

Physicians must regard their own levels of compensation as well as patient services under managed care as moral issues. In such systems, scarcity and abundance of resources are shared

Potentially beneficial treatment is likely to confer:	If plan does not clearly exclude, physician:	If plan clearly excludes, physician:	If plan gives discretion, physician:
1. minimal benefit	should advocate	may, but need not advocate	should advocate
2. more than minimal benefit	should advocate	should advocate	should advocate

Figure 1. Proposed physician obligations to provide potentially beneficial treatment chosen by a patient or surrogate in a health plan.

among patients. "Gaming" a health plan for one's own monetary gain or for the benefit of patients is unethical, because such actions violate duties of veracity and beneficence, and, in addition, violate the contractual justice and promise-keeping premises which underlie social contracts. As Morreim states:

Widespread gaming represents a systematic assault on patient-payer contracts. Payers and patients necessarily draw limits on their mutual obligations. Payers cannot agree to provide literally limitless care, any more than patients can pay literally limitless premiums. The physician who systematically undermines such legitimate limits through gaming not only threatens the integrity of individual agreements, he also invites economic anarchy by assaulting the confidence with which people can make such agreements in the first place.¹⁰

Physicians should cooperate with resource rationing within a health plan. They cannot ensure that resources saved in the care of a particular patient will necessarily accrue to needier patients, but it is clear that resources spent on a particular patient will not be available to others. Fiduciary obligations to patients do not include gaming the system.

Physicians have obligations as citizens and as health care professionals to involve themselves in fashioning resource allocation systems that are morally grounded. A general form of this obligation is part of our ethical code and has been discussed elsewhere.¹¹

THE INEVITABILITY OF A MULTI-TIERED SYSTEM

It is not clear what sort of national health services financing system we will have when the current congressional debate is completed. The possibilities range from predominantly market reform¹² to a British or Canadian style of monolithic, single level system. Many of the non-market reform proposals (we include Clinton's and related versions of managed competition in this group) place a high value on "equity" in providing health care to all citizens. But what kind of equity underlies such systems?

In considering the meaning of equity in health care, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research rejected the definition of equity as "equality."¹³ Equity as equality characterizes delivery systems such as a national health service (Britain) or an insurance model (Canada) under which each citizen is guaranteed the same level of health care. Examining the means by which health care might be equalized reveals inherent severe shortcomings. There are two ways health care resources can be equalized — levelling up or levelling down: to level up, social funding must provide each individual with the current high level of resource consumption available to those with private means; to level down, all must agree or be compelled to receive a lower level of care. The former is achievable only at the expense of other social goods, such as defense or the justice system. The latter is achievable at the expense of one's freedom to spend private dollars as one wishes. Blumstein and Sloan¹⁴ submit that neither of these alternatives is necessarily feasible nor desirable:

Levelling up would require such a staggering commitment of resources that other public priorities would unduly suffer; levelling down would promote gross inefficiency, lower quality, achieve a dubious sort of equity in which waiting time would be the main resource allocator, and threaten fundamental precepts of freedom by barring individual expenditures for health above some arbitrary limit set by government.

The President's Commission rejected the notion of equity as equality in health care, but embraced equity rather as an "adequate level of health care." This would provide a basic level of care for all while also permitting a stratified system characterized by inequality. Given the difficulties inherent in any attempt at levelling, a multi-tiered health care system seems inevitable in American society. The standard of care required of physicians, or what physicians owe their patients, must reflect this duality. The prospective reimbursement structure of managed care makes it unreasonable to expect physicians equitably to allocate resources which they do not own or control, as was possible under retrospective, fee-for-service reimbursement. This difficulty is addressed by Morreim's divided standards, the standard of medical expertise and the standard of resource use, discussed above.

FINANCIAL INCENTIVES

Not all financial incentives to limit care create the same degree of conflict between the physician's and others' interests and the patient's. The degree of influence of a financial incentive varies according to the percentage of the physician's income which is placed at risk, the frequency at which incentive payments are calculated, and the size of the group of physicians upon which the economic performance is judged. For example, a small group of physicians will feel the effects of sharing financial risk more intensely than a large group. In general, the threat to the quality of care increases when financial incentives are closely linked to treatment decisions about individual patients and to physician performance over short periods of time, and when there is a high level of financial risk to the physician.¹⁵ In addition, a for-profit managed care system may employ stronger financial incentives than a not-for-

profit arrangement because of the pressure to pay profits to shareholders.

Because of these difficulties, an important ethical obligation of health plans as moral agents¹⁶ is to avoid creating financial incentives for physicians to deny patients potentially beneficial treatment. Marc Rodwin argues that there are many reasons patients may be denied care: unavailability of resources and specific plan exclusions, for example.¹⁷ Pitting physicians' interests against patients' is too blunt an instrument, discouraging needed as well as frivolous treatment. We agree with this position, and suggest that there are parallel obligations of health plans not to offer and of physicians not to accept financial incentives to deny beneficial care to patients. Such incentives include, among others, hold-backs, bonuses, and penalties based on consumption of plan resources by patients.

It could be argued that under fee-for-service financing, the physician stood to benefit financially from treating patients, so too much or unnecessary care resulted. There is a fundamental difference between the two situations, however. Under the older fee-for-service system, the physician is responsible directly to the patient, and the patient is unequivocally the object of his loyalty. Under managed care, however, the physician's loyalty is divided between the patient, who is receiving the service, and the plan, which is paying the bill in the role of the patient's agent.¹⁸ There are therefore more frequent opportunities and greater temptations for the physician under managed care to act for interests other than the patient's. It is true that fidelity to patients' interests has not been universally honored by all physicians in the past, but nonetheless the concept has been a robust component of the identity of medicine as a profession. The growth of managed care in the past decade has been associated with clearly increasing fragility of that important aspect of our ethic.

The medical profession is at a watershed of identity.¹⁹ Two defining ethical positions are: (1.) We can accept as ethical any and all financial arrangements designed by health plans to control expenditures, including incentives for physicians to deny or withhold care in order to maximize their own incomes. This choice will move us away from the ethic of fidelity only to

the patient, toward an ethic based on divided loyalties. Or (2.) we can reject as ethically unacceptable financial incentives that place our obligations of fidelity to the patient at significant risk. There is a notable lack of data on outcomes of treatment associated with different kinds of financial incentives;²⁰ that is, we know very little about how the health of patients is affected by behavioral changes in physicians induced by managed care, or about its effect on patients' trust of physicians. It is therefore difficult to identify a middle ground between these two positions. Because of the central importance in medical ethics of physician fidelity to the patient's interests, the burden of proof that a particular financial incentive does not harm the relationship of trust of patient for physician lies upon those who claim there is no harm.

It seems clear to us that financial incentives pose a threat to the identity of medicine as a caring, protective, trusted profession. Unambiguous commitment to the Hippocratic tradition can be achieved by rejecting as unethical financial arrangements that undermine fidelity to the interests of patients. Such arrangements include rewarding (for lower resource usage in their patients' behalf) or penalizing (for higher usage) individual physicians or small groups of physicians over short periods of time. Risk-sharing by large groups of physicians over long periods of time (say, a year or longer) may pose less risk to the physician-patient relationship.

Health plans use financial incentives to change physicians' behavior and there is no doubt that they can be effective.²¹ Behavioral changes have two effects: they change resource usage and they move physicians away from choices (presumably in the patient's best interests) they would otherwise have made. These changes relate directly to each other: larger effects on resource usage are associated with greater movement of physicians' choices. Thus, there is a fundamental conflict between the goal of the health plan to reduce resource costs and the goal of the physician to serve the patient's best interest. Financial incentives that have little or no effect on physician behavior are the only ethically acceptable ones, but they also are of little or no value to the plan. In view of this standoff between the plan's financial interests and the physician's ethical obligations, one wonders whether there is any place for

financial incentives for physicians in managed care systems. Perhaps cost control can best be achieved through mechanisms that do not interfere with obligations of fidelity and do not threaten the patient-physician relationship. These may include explicit service exclusions, specific rules governing the decision process, and monetary limits on services. Such controls can be administered by non-physicians under Morreim's standard of resource use. Their effect on quality of care is not clearly understood and should be studied to quantify possible effects.

When a customer engages in ordinary business interactions, the governing rule is caveat emptor. This is not the expectation of a patient entering a hospital or doctor's office; rather, the expectation, supported by thousands of years of tradition, is that the physician will act as fiduciary to the patient. This circumstance places an extra burden of honesty and truthful advertising on both physicians and health plans to notify potential patients of the existence, nature, and magnitude of cost control measures, both physician incentives and service limits, that might result in denial of care.

Financial incentives are not the only threat to the physician-patient relationship under managed care. There will be other more subtle incentives to deny care. For example, package pricing is becoming widespread. A contract between a large company and a health plan may set a specific price for an operation, for example a coronary bypass, including all hospital and physician services. This price is paid for every such operation, regardless of cost. Pressures from administrators within the plan may be brought to bear on cardiologists and surgeons not to operate on patients with multiple comorbidities who are therefore likely incur costs substantially higher than the contracted price. Moreover, mortality rates are likely to become one of the criteria by which companies choose health plans. Administrators of the plan are then likely to influence physicians to deny coronary bypass operation to a patient with higher (say, five to 10 percent) risk than the average patient (about one to two percent) because of the upward effect on mortality rate (this problem is unlikely to be solved soon by risk adjustment, because outcome assessment is a developing technology). Thus, there will be

pressures on physicians to deny care to some patients (for example, by declaring them inoperable); the heart patient with diabetes, peripheral vascular disease and chronic renal failure who is likely to require high cost intensive care for more than a day or two; the patient with a low left ventricular ejection fraction and a "high" mortality risk of 15 percent). Physicians should be aware of subtle pressures to ration care in this manner, and should not succumb to them. Rather, criteria for exclusion should be explicitly described by the plan.

ADDITIONAL CONSIDERATIONS

Health care reform is likely to bring patients into the health care system who are of low economic status and not of social stature equivalent to that of the physicians caring for them. This may exacerbate existing problems in medical ethics. Wolf suggests⁶ that self-determination is most likely to be based on truly informed and valid consent when three conditions are met: (1.) the physician and patient can easily communicate with one another; (2.) the patient trusts the physician enough to communicate his real preferences; and (3.) the patient has enough real options to make self-determination meaningful. All these are currently problems for some patients. For example, poor black women may not communicate well with physicians, and are more likely than other women to suffer punitive measures for drug abuse during pregnancy; there is a low level of trust of physicians and the health care system by such women. Moreover, patients in nursing homes often lack choice, control, independence, and the ability to articulate choices clearly, so have few real options for meaningful self-determination.

Physicians are obligated to do more than give information and respect choices of patients; in addition, they should identify and overcome barriers to clear communication. By helping patients to find resources they may not have known existed, physicians may help to create more options, allowing greater self-determination for such patients.

The South Carolina Medical Association has an important advantage over many other state medical associations. Managed care has not yet gained as substantial a share of our health insurance market as it has in other states. We are

therefore in a position proactively to propound and observe guidelines designed to maintain our Hippocratic identity to an extent not possible elsewhere; for example in Massachusetts, California, and other states the livelihoods of many physicians already heavily depend on health plans that use the most pernicious types of incentives. Despite perceptive works like those of Morreim and Wolf, the bioethics community in this country has not developed a consistent position on the ethics of managed care, leaving the medical profession with little guidance on how to respond to perceived threats to professional integrity. The guidelines we suggest may be a model for other states.

ETHICAL GUIDELINES

1. Physicians must abide by the rules of the health plan in financial matters and in provision of services, but are encouraged to challenge the rules within an established appeal mechanism when advocating for a patient.
2. Physicians must inform patients of medically appropriate, potentially beneficial service alternatives, regardless of cost or coverage by the plan; they should not allow concern for desirable outcome statistics to interfere with informing or advocating for patients.
3. Physicians should encourage the plan to anticipate conflicts between medical judgment and policies in routine practice and in emergencies, and help establish routes for routine and urgent appeals.
4. Physicians should advocate (provide or, in case of denial by the plan, appeal) on their patient's behalf for all services that may be beneficial and are not excluded by the plan, and excluded services that are more than minimally beneficial. They may but are not ethically bound to advocate on the patient's behalf for excluded services that are only minimally beneficial.
5. Physicians should insist that any plan in which they participate use no system of financial gains and losses that encourages physicians to limit beneficial services they may offer to patients.
6. Physicians must assure that their contractual agreements restricting referral or limiting service options are disclosed to patients (acceptable mechanisms of limiting ser-

vices include exclusions and procedural rules specified in the plan-patient contract), and that the plan makes adequate disclosure to all patients prior to enrollment.

7. Physicians should promote an effective program of peer review to monitor and evaluate the quality and appropriateness of patient care services provided within their practice settings.
8. Physicians are responsible for medical decisions and quality of care, irrespective of conclusions reached by reviewers; they must act always on the basis of their own best judgment.
9. Physicians should make special efforts to overcome barriers to clear communication with patients of cultural and socioeconomic status different from their own, respect their values, and help to identify resources that will increase options and optimize self-determination.
10. Physicians should not refer patients to colleagues they feel may not be competent, even if the referral is mandated by the plan; moreover, when an issue of competency has been raised, there should be an established policy to evaluate the charges and make disposition, while respecting confidentiality and privacy of all concerned parties.
11. Physicians should, in their roles as citizens and as health care professionals, help to fashion resource allocation systems that are morally grounded. □

REFERENCES

1. Sade RM. A new code of ethics. *J So Carolina Med Assoc*; 86:163-166, 1990.
2. Levinsky NG. The doctor's master. Cited in: Morreim EH. *Balancing Act: The New Medical Ethics Of Medicine's New Economics*. (The Netherlands, Kluwer Academic Publishers, 1991), p. 45.
3. Veatch RM. DRGs and the ethical reallocation of resources. In Morreim EH. *Balancing Act*, p. 45.
4. Morreim EH. *Balancing Act*, p. 47.
5. We will use the term health plan or simply plan to refer to any type of managed care organization throughout this essay.
6. Morreim EH. Rationing and the Law. In: *Rationing America's Medical Care: The Oregon Plan And Beyond*. The Brookings Institution, Washington, DC, 1992.
7. We acknowledge the ambiguity inherent in the term "beneficial." It means "of benefit," but who decides what is of benefit? The physician is in a position to say what treatments are effective in a physiological sense, but the patient's values must be the major determinant of the "value" of a particular intervention. For

a more detailed discussion, see Truog RD, Brett AS, Frader J. The problem with futility. *New Engl J Med*; 326:1560-3, 1992; and Sade RM. Medical Futility and ineffective care: a proposal for hospital policy. *J So Carolina Med Assoc*. In press.

8. Wolf SM. Health care reform and the future of physician ethics. *Hastings Center Report*; 24(2):28-41, 1994.
9. Code of Medical Ethics: Current Opinions. Council on Ethical and Judicial Affairs. American Medical Association. Chicago, Sections 8.15, 9.031, 9.04, 9.11, 1992.
10. Morreim EH. *Balancing act*, p. 81.
11. See SCMA Principles of Ethics, Principle VII, and the accompanying discussion in Sade, 1990.
12. Sade RM. Health care reform: implications for American medicine. *Ann Thorac Surg*; 57:792-6, 1994.
13. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. *Securing Access to Health Care* (Government Printing Office, 1983), vol. 1, p.20. The commission recognized the necessity of a two-tiered health care system because "trying to prevent such inequalities would require interfering with people's liberty to use their income to purchase an important good like health care while leaving them free to use it for frivolous or inessential ends. Prohibiting people with higher incomes or stronger preferences for health care from purchasing more care than everyone else gets would not be feasible, and would probably result in a black market for health care," 18-19.
14. Blumstein JF, Sloan FA. Redefining government's role in health care: Is a dose of competition what the doctor should order? *Vanderbilt Law Review*; 34:p. 865. In: Morreim EH: *Rationing and the law*. p.163, May 1981.
15. The Council on Medical Service and the Council on Long Range Planning and Development. American Medical Association. *Managed Care*. Ethics Newsletter, American Psychiatric Association; vol VIII (1):1-12, 1992.
16. The idea that health plans are moral agents and have moral obligations is discussed and affirmed by Wolf. Wolf SM. Health care reform and the future of physician ethics. *Hastings Center Report*; 24(2):28-41, 1994.
17. Rodwin MA. *Medicine, Money, And Morals: Physicians' Conflicts Of Interest*. New York: Oxford University Press; 232-3, 1993.
18. Sade RM. The different drummer, the double agent, and future dilemmas in bioethics. *Ann Thorac Surg*; 52:183-190, 1992.
19. We have discussed earlier the role of the expressed ethics of a group or association in portraying its chosen identity. See Sade, 1990.
20. Hillman AL, Gauly MV, Kerstein JJ. How do financial incentives affect physician's clinical decisions and the financial performance of health maintenance organizations? *New Engl J Med*; 321:86-92, 1989.
21. Hillman AL. Financial incentives for physicians in HMOs: is there a conflict of interest? *New Engl J Med*; 317:1743-8; 1987; Hemenway D, Killen A, Cashman SB, Parks CL, Bicknell WJ. Physicians' responses to financial incentives: evidence from a for-profit ambulatory care center. *New Engl J Med*; 322:1059-63, 1990.

GENETIC SCREENING AND COUNSELING: ETHICAL CONSIDERATIONS

J. RICHARD SOSNOWSKI, M. D.*

OVERVIEW OF GENETIC TESTING

"The history of man for the nine months preceding his birth would, probably, be far more interesting and contain events of greater moment than all the threescore and ten years that follow it."¹

Genetic testing is reported to be the fastest growing area in medical diagnostics. The Office of Technology Assessment estimates that the number of genetic tests will increase tenfold in the next decade. Already hundreds of thousands of fetuses are being tested every year by amniocentesis and chorionic villus sampling.² Recently pre-implantation embryos have been biopsied for genetic screening.³

Postnatal testing includes biochemical assay, chromosome analysis, identification of a genetic marker linked to a faulty gene, or identification of the gene itself.⁴ In the past year, researchers have found genes associated with Alzheimer's disease, Huntington's disease, and colon cancer, and expect to confirm a breast cancer gene almost any day. With this testing people could be warned that they are at special risk for those diseases and, when used in conjunction with prospective therapies that replace defective genes with working ones, genetic tests could lead to real cures.

We now have DNA tests for numerous X chromosomal gene defects (e.g., the high frequency fragile X mental retardation syndrome), autosomal dominant conditions (e.g., polycystic kidney disease, myotonic dystrophy, colonic polyposis) and autosomal recessive diseases (e.g., cystic fibrosis and thalassemia).⁵ Peters predicts that the identification of genes associated with susceptibility to

common disorders such as breast cancer will propel this specialty into the area of preventive health care.⁶

Genetic testing generally is done for one or more of five purposes: detection or exclusion of defective genes, treatment of genetic disorders, reproductive counseling, sex determination, and prediction of possible outcomes to the patient and to family members. For genetic screening to be useful and successful, Bost has suggested three requirements:

1. screening must lead to clear diagnosis;
2. clear information on risk(s) must be available;
3. a beneficial solution must be possible.⁷

Modell suggests other important factors: the condition should be common and important, screening should be affordable, and the solution should be acceptable to the population concerned.⁸

Until recently, the methods employed to prevent the delivery of an infant with a serious genetic defect have been to avoid reproduction altogether, to avoid reproducing with certain mates, to obtain materials from an existing pregnancy by amniocentesis, or earlier by chorionic villus sampling and, if a serious genetic defect was found, to abort the fetus. Now, extending the techniques of in vitro fertilization (IVF), pre-embryos can be biopsied for analysis of their DNA prior to implantation. Hammersmith Hospital in London screens for all recessive gene disorders by this method. The Ontario Hospital in Canada screens for only specific and severe X-linked disorders. It is believed that pre-implantation genetic screening will reduce the need for genetically related first and second trimester therapeutic abortions and also save the parents-to-be from the lengthy wait to learn whether they will, in fact, have a

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healthy child.⁹

Some time ago, four criteria were established as prerequisites for testing to screen newborns: first, that there be a disease, not simply laboratory variation; secondly, that the disease should cause serious problems, such as mental retardation or early death; thirdly, that the problems caused by the disease be amenable to treatment directed at preventing symptoms; fourthly, that a marker for the disease be identifiable in the newborn prior to the appearance of symptoms and before the biochemical abnormalities of the disease produce irreversible damage.⁹ As time has passed, this strict application of classical criteria has been modified so that total elimination of the appearance of symptoms is no longer required. Instead, it is acceptable if there are some benefits from early detection even if complete prevention of disease is not possible. For instance, in patients with cystic fibrosis, severe morbidity and mortality within the first year of life may be avoided through early intervention with antibiotics and pancreatic enzymes. In patients with sickle cell disease, the initiation of antibiotic therapy can prevent death from overwhelming bacterial infection during infancy. Although not all the long-term consequences of these disorders are altered by early identification and treatment, the benefits derived therefrom are considered adequate reasons for screening.¹⁰

Originally, the intent of screening was to benefit the newborn; identification of carriers was secondary. In the future, a major goal of screening may be identification of carriers to allow appropriate reproductive counseling, without any direct benefit to the newborn.¹¹

In addition, genetic testing can be used to identify defects that are not a risk for the patient's offspring but a risk for the patient. Testing may show that the patient may suffer from a late-onset disorder or that the patient is at risk for developing a particular disease when exposed to environmental stimuli. Also, recent research has indicated that carriers of single gene recessive disorders might have a predisposition towards developing other types

of health problems.¹²

The consequences of testing need to be considered in light of the effect on the individual tested, the effect on that individual's relatives, and the vulnerability of the individual to genetic discrimination in terms of insurability, employability, and admission to certain institutions (educational, military, and the like). The questions that must be answered include: who gets tested; who gets the results of the testing; how can privacy be protected; how far should confidentiality extend; how can informed consent be assured?

From the perspective of ethics, genetic counseling should precede any use of prenatal diagnosis. The purpose is the education and preparation of individuals for the choices they must make during the informed consent process of prenatal diagnosis. Genetic counseling has been defined as follows: "A communication process which deals with the human problems associated with the recurrence, or the risk of occurrence, of a genetic disorder in a family."⁹ Thus, genetic counseling is equally important in the genetic diseases which present in adult life because many are dominantly inherited. This means the diagnosis of one family member may reveal that relatives are at risk for developing the same disease. Forewarned of this risk, they may avail themselves of medical intervention and also have the opportunity to consider reproductive options before it is too late.⁵

DISCUSSION

The ethical principles of respect for persons, beneficence, non-maleficence, proportionality and justice, so well known in medical practice and research, should apply to genetic screening and counseling. Genetic counseling and screening practiced under these principles have much to offer. However, not all the ethical problems that arise in genetic screening have clear and generally accepted answers.

A basic moral question arising in the context of genetic screening is the moral status of the embryo. For example, pre-implantation

genetics, as currently practiced, involves the manipulation and destruction of embryos. A blastomere is removed from the embryos created by in vitro fertilization (IVF), and if the DNA problem of the blastomere is positive, the embryo is discarded. When the positive test is for gender because of an X-linked genetic disease, half of the discarded male embryos would be healthy and presumably could implant and develop to term fetuses. Even if the test is negative, the biopsy itself may have done damage to an otherwise healthy embryo, thus causing its destruction rather than successful implantation.

Is this ethically acceptable? One view is that all human beings including embryos have the right to remain alive. Another view is "that embryos are not themselves persons or moral subjects with rights because of their very rudimentary stage of development. Consisting of undifferentiated cells that have not yet been established as individual, embryos may be valued because of the human potential that they represent or symbolize and are thus accorded more respect than human tissue. However, it does not follow that they are persons or moral subjects in their own right to whom are owed the moral duties owed to persons."¹³

Two "slippery slope" concerns have been voiced about pre-implantation genetic diagnosis. One is that it will open the door to embryo selection for reasons other than prevention of serious disease. Another is that there will be an extension to active alteration of embryo genes to engineer offspring characteristics. Both possibilities may fuel fears of eugenic programs in the future like those under totalitarian regimes in the middle part of this century when totalitarian abuses of eugenic ideas arose from application of genetic knowledge toward social goals. The proponents of pre-implantation screening do not believe that the likely occurrence of either of these "slippery slope" arguments is sufficient to ban embryo screening for indications that are independently acceptable. Indeed to prohibit embryo biopsy or embryo discard is considered by some to impinge on the procreative liberty of couples

at risk for genetic disease.¹⁴

Another argument favoring pre-implantation screening is that couples do not have an obligation to have genetically affected offspring if reasonable means of avoidance exist. "It is no more unnatural or artificial to seek healthy children by prenatal selection than it is to treat genetic defects medically once they have occurred...as long as the choice is freely and privately made, without government coercion, the decision to avoid the birth of offspring with severe genetic disease is not unethical and may reasonably be considered within the realm of procreative choice."¹⁵

Also, pre-embryo screening provides another choice to couples who have problems with the concept of therapeutic abortion or who required assistance to overcome their infertility.¹⁴

Reporting of test results involves issues of confidentiality. A 1985-86 survey of geneticists in 19 nations revealed that close to 100 percent of them would disclose ambiguous, conflicting or controversial test results; would not disclose non-paternity to a woman's partner; believe that genetic counseling should be non-directive and that counseling should help to facilitate and support patients' own choice; and that employers and insurers should not have access to an individual's test results without an individual's consent.¹⁰

However, suppose that screening reveals an unambiguous genetic defect and the patient refuses to notify the patient's relative(s). What is the physician's responsibility? Factors to be weighed are: the likelihood the relative has the genetic defect; the seriousness of the defect to the health of the relative and his children, and the likelihood that the relative's defect would be otherwise detected. The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research recommended that disclosures without the patient's consent should be made only if reasonable attempts to elicit voluntary disclosure are unsuccessful, there is a high probability of serious harm to an identifiable third party, there is reason to believe that disclosure of the information will

prevent harm and the disclosure is limited to the information necessary for treatment of the third party.¹¹ This disclosure policy should be included in the informed consent process. In terms of patient responsibility, since his genes are shared with his parents, siblings and children. If he discovers that he carries a potentially harmful gene, he may have an ethical obligation to tell them.¹

A distinguishing feature of American health care is its high regard for the principle of respect for autonomy. Generally, persons are considered to have the right to decide what should be done to their own bodies. Since genetic testing takes place in the context of the patient's values, we cannot presume a patient's views until he or she expresses them after being fully informed about the nature of the test and its clinical and social implications. The principal expression of autonomy is informed consent. The responsibility of the physician in the clinical setting is to provide help and avoid harm to the person or families seeking assistance; whereas the primary responsibility of the physician in medical research may be to develop knowledge to accurately reflect biological and social realities, and this may not be directly helpful to the people involved.⁵

Genetic testing should not be used to determine employability because such tests are not reliable predictors of disease and even less reliable predictors of disabling disease. This is due to the fact that genes may be characterized by incomplete penetrance and variable expression; thus individuals who carry the gene may never show manifestations of it. Even when the gene ultimately would cause disabling disease, the disability may not appear for some time.

Higher health costs are not recognized by the Americans with Disability Act as a justification for screening potential employees, although the Act does permit employers to take health risks into account when issuing employee health and other insurance. Moreover, it expressly prohibits employers from using risk underwriting insurance as a sub-

terfuge to evade the anti-discrimination purposes of the Act. At present there is insufficient evidence to justify the application of any existing test for genetic susceptibility as a basis for employment decision.¹⁵

A major concern about genetic screening is that the results may jeopardize the individual's insurability. A survey of medical directors of life insurance companies suggests the following:

1. few insurers perform genetic tests on applicants, but most are interested in accessing genetic test information about applicants that already exists;
2. the degree of insurers' interest in using genetic test results may depend on the face amount of the policy applied for and on the specificity and sensitivity of the test;
3. many companies employ underwriting guidelines with respect to certain genetic conditions but may not always have specific actuarial data in house to support their rating decisions;
4. a considerable degree of subjectivity is involved in most insurers' rating decisions;
5. some of the medical directors who responded to the survey were not fully informed about certain basic principles of medical genetics.¹⁶

Insurance companies may argue that the results of genetic testing should be available to them because applicants may withhold significant information from the insurer and choose excess amounts and types of insurance that are most beneficial to themselves. A problem also occurs if the insurer is denied access to or use of information pertinent to the risk being considered. The end result in both cases is that the low risk clients in the insurance pool subsidize the ones with high risks about whom the insurance company does not know.⁷

According to Philip Riley, during the '90s the cost of health care and the powers of genetic testing, especially for presymptomatic diagnosis, will drive employers, insurers and

others to use their tests as screening and cost control tools.¹⁸ There is also the question of who should pay for pre-implantation genetic screening because some consider IVF to be a luxury, and pre-implantation screening just adds to the cost of that procedure. On the other hand, screening may help reduce the number of severely handicapped children being born, thus saving money.³

ETHICAL GUIDELINES FOR GENETIC SCREENING

As we have seen, genetic screening raises serious ethical issues. The following guidelines are founded upon the conviction that individuals have freedom of choice in personal health matters, the right to work and to conduct this pursuit in a safe place, and the right to privacy.¹⁹

1. Genetic screening, including pre-implantation screening to detect serious genetic disorders, is permissible.
2. With the increasing collection of genetic material, utmost respect for the privacy of the individual and strong adherence to the principle of confidentiality must be observed. When serious harm to an identifiable third party may occur, the physician may disclose the pertinent genetic information to the third party only if: (a) the individual with the defective gene cannot be persuaded to make disclosure to the appropriate persons, and (b) he was advised before being tested that the physician in that case would make the disclosure.
3. Physicians should contribute to the development of clear and ethical guidelines for DNA databanks, and should not deal with databanks that do not meet these guidelines. A good example of such guidelines has been proposed by Annas²⁰ (see Appendix, p. 78).
4. Physicians should not use the results of genetic screening to contribute to discrimination by employers and insurance companies against people with genetic disorders

and should not as employers themselves use this information to discriminate against persons with genetic disorders.

5. A physician should not give false information about the results of genetic screening but may advise the patient on the benefits and risks of disclosing screening information to insurance companies, employers, and other third parties. □

REFERENCES

1. Coleridge ST. *Miscellanies, Aesthetic and Literary*, 1803.
2. Rennie J. Grading the gene tests. *Scientific American*, 88, June, 1994.
3. Johnson C. New program at Ontario hospital will screen pre-embryos for genetic disease. *Can Med Assn J*; 148(4):605, 1993.
4. MacGregor E. Dilemmas in genetic screening. *Nursing*; 4(41):13, 1991.
5. Danks DM. Whither genetic services? *Med J Aust*; 159(4):221, August 16, 1993.
6. Peters JA. Commentary, *Hastings Center Report*; 30, Sept.-Oct. 1993.
7. Bost N. Genetic diagnosis and treatment, ethical considerations. *Am J Dis Child*; 174(11):1190, November, 1993.
8. Modell B. Ethical aspects of genetic screening. *Ann Med*; 24(6):549, December, 1992.
9. Guthrie R. Organization of a regional newborn screening laboratory. In *Neonatal Screening Inborn Errors of Metabolism*. Edited by Bickel H, Guthrie R, Hammerson, G. Berling, Springer-Verlag: 259-270, 1980.
10. Levy H. *Yale J Biol Med*; 64:17, 1991.
11. Wertz DC, Fletcher JD. Geneticists approach ethics: An international survey. *Clin Genet*; 43:104, 1993.
12. Andrews LB. Legal aspects of genetic information. *Yale J Biol Med*; 64:29, 1991.
13. Robertson JA. Ethical and legal issues in pre-implantation and genetic screening. *Fert Steril* 57:1, 1992.
14. Nisker JA. Screening for genetic disease. *Can Med Assoc*; 149(4):392, 1993.
15. Council on Ethical and Judicial Affairs, American Medical Association. Use of genetic testing by employers. *JAMA*; 166(13):827, 1991.
16. McEwen et al. A survey of medical directors of life insurance companies concerning use of genetic information. *Am J Human Genetics*; 53:33, 1993.
17. Pokorski R. Genetic screening and the insurance industry. *Yale J Biol Med*; 64:53, 1991.
18. Riley P. Rights, privacy, and genetic screening. *Yale J Biol Med*; 64:63, 1991.
19. Billings PR. The context of genetic screening. *Yale J Biol Med*; 64:67, 1991.
20. Annas GJ. Privacy rules for DNA databanks. *JAMA*; 270(19):23246, November 17, 1993.

APPENDIX

1. No DNA databank should be created or begin to store DNA samples until there is:
 - a. public notice that the DNA databank is to be established, including the reason for the bank;
 - b. a privacy impact statement prepared and filed with designated public agency that is also responsible for developing and enforcing privacy guidelines for the DNA bank (ultimately a DNA databank-licensing board should be established to license all DNA databanks in the United States with uniform rules);
 - c. the burden of proof should be on the DNA bank to establish that storage of DNA molecules is necessary to achieve an important medical or societal goal.
2. No collection of DNA samples destined for storage is permissible without prior written authorization and agreement that:
 - a. sets forth the purpose of the storage;
 - b. sets forth all uses, including any and all commercial uses, that will be permitted of the DNA sample;
 - c. guarantees the individual
 1. continued access to the sample and all records about the sample;
 2. the right to correct inaccurate information;
 3. the absolute right to order the identifiable sample destroyed at any time;
 - d. guarantees the destruction of the sample or its return to the individual should the DNA databank significantly change its identity or cease operation;
3. DNA samples can be used only for the purposes for which they are collected, and linkages to other computerized information systems are prohibited. Specifically there may be
 - a. no waivers or boilerplate statements that permit other uses;
 - b. no access to the DNA information by any third party without written notification to the individual whose sample is being used;
 - c. no access by third parties to any personally identifiable information;
 - d. strict security measures, including criminal penalties or misuse or unauthorized use of DNA information.
4. Mechanisms should be developed to notify and counsel those whose DNA samples are in storage when new information that can have a significant health impact on the individual is obtainable from their stored DNA sample.

Editorials

MEDICAL ETHICS AND THE SCMA

Interest in the subject of medical ethics has steadily increased over the last 20 years as complex social and legal issues have caused physicians and their patients to seek objective answers which are in the best interests of all parties involved. The discipline of ethics and the formation of medical ethics committees have worked well in developing solutions to some of these issues.

The SCMA's Medical Ethics Committee is somewhat unique in that non-physician consultants, all experts with diverse relevant educational backgrounds, have always been a part of the committee along with the physicians, and freely participate in the development of positions it takes. Thus, beneficence, non-paternalism, and justice are important even at the committee level.

The articles published in this issue of *The Journal* were developed in a variety of settings. Since 1990, the committee has held an annual winter retreat to study in detail a broad topic in medical ethics. The articles concerning biological perspectives on the beginning of life and theological perspectives on the beginning and end of life were two of the products of a 1993 retreat during which the committee explored ethical issues relating to the beginning and end of life. The article on ethics and managed care systems was developed during the committee's 1994 retreat. At the retreat, members were honored to have as a special guest and participant John Glasson, M. D., Chairman of the Council on Ethical and Judicial Affairs of the American Medical Association.

The committee has worked on issues concerning end-of-life decisions for some time. Some of the most difficult decisions in medicine today concern the just allocation of resources, especially at the time of death.

This topic includes such issues as the rights of physicians and patients in making clinical decisions concerning medical treatment, whether some care should not be given because it is by definition futile and wastes resources, and the rights of third parties to make decisions for patients who cannot speak for themselves. The articles on DNR policies and medical futility were originally developed as statements by SCMA's Medical Ethics Committee. These statements were sent to the SCMA Board of Trustees for approval. The board approved the statements and requested the South Carolina Hospital Association to participate in a joint effort to produce information to be used as guidance material to South Carolina physicians and hospitals. The joint SCMA/SCHA committee produced the final documents appearing herein.

The committee also meets monthly at SCMA Headquarters. The article on genetic testing is the product of six monthly meetings of the committee.

Aristotle stated that ethics are practical virtues. We know medicine is both art and science. The Ethics Committee hopes you find these articles interesting and useful as you practice the art and science of medicine. Our ultimate goal as a committee is to provide helpful information to SCMA members. We express our gratitude to Charles S. Bryan, M. D., Editor of *The Journal*, for allowing us to publish this special issue, and to Joy Drennen, Managing Editor, whose special skills and extraordinary patience helped to make this issue a reality.

John M. Roberts, M. D.
222 West Coleman Boulevard
Mt. Pleasant, SC 29464.

On the Cover:

THE SCMA AND EUTHANASIA

The South Carolina Medical Association was perhaps the first American medical group to address the problem of "active" euthanasia in open debate. In the Annual Meeting of 1878, at the request of an absent member, Dr. T. T. Robertson, the following committee was appointed to "draft a report, to be presented at the next annual meeting, on the subject of 'Euthanasia:'" Dr. J. F. M. Geddings, Chairman, and Drs. R. A. Kinloch and F. F. Gary.

At the 1879 Annual Meeting, Dr. Geddings reported that the committee did not feel competent to deal with the subject and had consulted many authorities. They had considered the issue from several aspects: medical, religious, moral, ethical and legal. Medically, they could find no precedent to the taking of life except to save a life. Morally, the committee felt that "in some cases humanity might be entitled to the same mercy accorded the brute creation, and have its death artificially hastened to relieve it from an agony which could only end in dissolution," but even in this, they saw a prospect of "manifold horrible abuses." The committee felt that it could not proclaim a practice ethical which was contrary to "the uses of society." A part

of the religious objection was that "a certain amount of suffering was the Divine decree." From the legal aspect, euthanasia was illegal and "could only be regarded as the practice of murder."

In the discussion that followed the report, many differing views were presented. Dr. F. P. Porcher warned of dangers inherent in the practice and told of cases where patients for whom there was no hope of recovery recovered.

Dr. J. Ford Prioleau unhesitatingly denounced the practice from "religious, ethical, legal, and every point of view." He agreed with the statement that "he who shortens life, takes it."

Dr. Robertson felt that euthanasia was as sure to be accepted as the "doctrine of evolution and that would be as surely as the Copernican system of astronomy." He believed that physicians could, under certain conditions, be justified in shortening life and admitted that he had done so. Further, he was prepared to do so again, under the right circumstances.

Betty Newsom
The Waring Historical Library



Alliance Page

MEMBERSHIP ROUNDUP

The South Carolina Medical Association Alliance is experiencing a very successful year. Under the capable leadership of President Donna Abercrombie, President-Elect Kiki Sanford, and Membership Chairman Janelle Othersen, county alliances around the state are accomplishing great things. Taking a cue from the American Medical Association Alliance's "One Choice...One Voice" focus, counties have been supplied with wonderful membership material and ideas. Many creative suggestions for membership retention have been generated and the call to "Membership...Loud and Clear this Year" has been answered in a positive way. Some of the membership recruitment ideas being tried are:

1. Statewide Phone-A-Thon
2. Gift Certificates for membership as holiday or birthday gifts.
3. County Membership Committee members personally contacting any member who has not renewed their membership by January 1st.
4. Special recognition for those counties with large increases in membership.
5. To encourage the exchange of ideas, a Suggestion Box will appear in *Newsline* (The AMAA Newsletter) featuring innovative and successful ideas for recruiting members.
6. Statewide membership meeting. This is the first attempt at a state meeting aimed directly at membership.

As this issue goes to press, we are very excited about this Membership Symposium which will be held from 10:00 a.m. to 12:30 p.m. on Thursday, February 2 at SCMA headquarters. The panel will be made up of presidents from five counties throughout the state, and our National Membership Representative, Susie Reeder, from Florida. Panelists are asked to share their experiences and efforts with membership development and recruitment. Our hope is that everyone who attends will leave with a new idea or attitude toward membership.

All of the above activities, plus many more, add up to positive numbers. To date, SCMAA has 879 AMA Alliance members, 947 SCMA Alliance members, and 17 Resident Physician/Medical Student Spouse members. These numbers will continue to grow as the year progresses.

Membership is the lifeblood of any volunteer organization. The important goals set by SCMAA can only be accomplished with a "healthy" membership base. SCMAA enters 1995 Alive, Well, and ready to face an exciting future!

Shirley Meiere
SCMAA Eastern Regional Vice President

Classifieds

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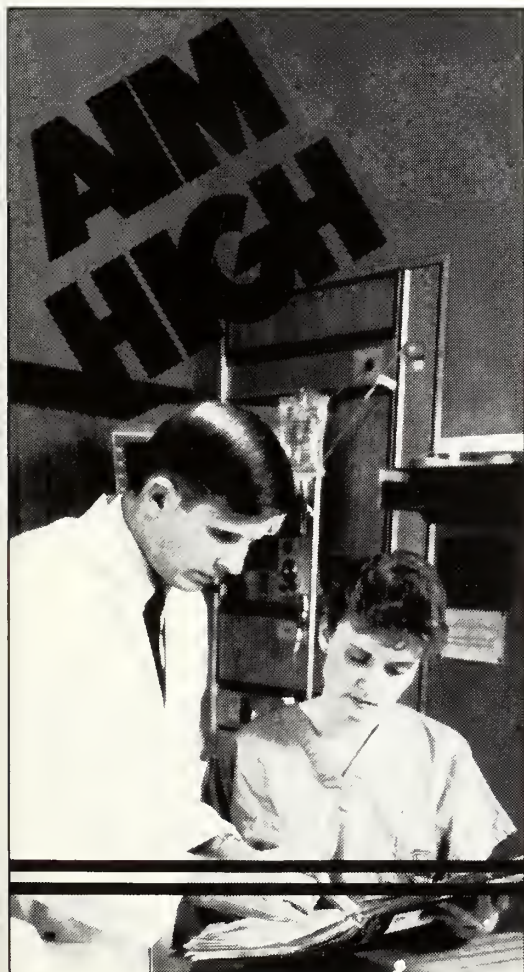
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ATRIAL MYXOMA
ELECTROCONVULSIVE THERAPY
COMPUTERIZED EKG INTERPRETATION
DIGOXIN DOSING

FRANCIS A. COUNTWAY LIB OF
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By Dr. Robert Faucett

Clients often ask for some general rules to be aware of to assist them in maintaining a prudent and realistic view of the investment market while they see the plethora of investment literature come their way.

1. **GET A PRO:** Investing is no place for amateurs (any more than the NFL). Be sure you have sensible professionals managing your investments. Get a fee-only, state-of-the-art advisor that employs the highest level technology and also provides recommendations that are in your best interest.
2. **CREATE A PLAN -- AND STICK WITH IT:** Write out your long term investment goals and plans -- and stick with it! "Plan your play, and play the plan". Utilize state-of-the-art planning to help you determine your own individual goals. Stick to this plan and update it at least every other year.
3. **YOUR HOME IS YOUR CASTLE:** Don't think of your home as an investment. Think of it as a place to live with your family, period. Except when inflation surges -- as it did in the late 1970s -- and lifts the replacement cost of real estate and drives bond prices down, owning residential real estate is not a great investment. Over the past twenty years, home prices have risen less than the consumer price index (inflation) and have returned less than Treasury Bills. When you own a home with a mortgage you have a leveraged investment. When you look at your over all net worth, owning a home and office is generally enough real estate exposure. Local real estate is very non-diversified, just ask any Texan who lived through the recession in the 1980s or any Californian in the 1990s.
4. **SAVE:** Hold savings as an expense and it will happen.
5. **THE REAL THREAT TO YOUR ECONOMIC FREEDOM:** Remember that while price fluctuations command our attention, the real problem for investors is inflation. Price fluctuations come and go. Inflation persists and is unrelenting in the damage it does. You usually don't notice inflation while you are in your production (working) years as your income and expenses keep up with inflation. The hardest part of an individual's long term game plan is the inflation-adjusted cost of living in later years. Inflation is insidious and the benefit of using a fee-only financial planner to keep you invested and on track cannot be overstated.

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President's Page

A TRIBUTE TO DR. COLVIN

The Spartanburg health care community honored one of its own in February with a superb reception and ceremony recognizing the myriad accomplishments of Dr. Euta Colvin. During the evening it became apparent that the local feats of this distinguished physician were a mirror of his legacy as a state and national champion of our beloved profession. Doctors and their patients all over South Carolina are deeply indebted to this noted surgeon. For many of us, he is the role model for participation in and contributions to organized medicine.

My first recollections of Dr. Colvin were of his wisdom and firmness as the representative of the Ninth Medical District to the SCMA Council. Strategic planning was clearly showing that our association had to change in order to meet the challenges facing South Carolina doctors. Euta's vote was obvious, decisive, and cast without regard to how it would affect his own aspirations if his side lost. Other members of Council rallied to this strength and the SCMA is more effective and successful today as a result. As our 118th president, he had the courage to implement many features of the strategic plan. Later, as an AMA Alternate Delegate, Euta was the catalyst for many changes that followed in our delegation. I was a young pediatrician serving as a member and later Chairman of the Public Relations Committee of the SCMA at the time, and the mentoring I received from interacting with Dr. Colvin and "watching him work" in organized medicine has proved invaluable to me.

More importantly, Dr. Colvin's commitment to his fellow physicians and to our state continued even as an SCMA past president. Under his leadership, the Risk Management Committee dealt effectively with the looming professional liability crisis in South Carolina. Through his writings and careful selection of speakers for workshops, South Carolina doctors truly knew how to manage risk in this litigious era. Likewise, the South Carolina Joint Underwriting Association (JUA) is highly successful as indicated in our stable professional liability premiums. Somehow in all of this, Euta found the time and energy to serve as President of the South Carolina Institute for Medical Education and Research (SCIMER). The path he set for SCIMER has led it to a highly successful Section 170 endowment program which will help fund the education and research accomplishments of young physicians for years to come.

Casey Stengel, when congratulating a player on the field who had done something particularly helpful to the team's efforts, would often shout from the dugout "you done splendid!" Dr. Colvin—you too have done splendid for your colleagues who follow. Finally, Dorothy (Mrs. Colvin), you have been a supportive partner in Euta's professional accomplishments, and we are indebted to you for this. We wish you both the best.

O. Marion Burton MD

O. Marion Burton, M. D.
President

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MAR 31 1995

The Journal



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ATRIAL MYXOMA: DIAGNOSIS AND TREATMENT

L. DIETER VOEGELE, M. D.*

WILLIAM H. PRIOLEAU, M. D.

P. REID LOCKLAIR, M. D.

R. RANDOLPH BRADHAM, M. D.

The diagnosis of atrial myxomas can be difficult because of the protean nature of their presentation. Patients may present with any or all of the triad described by Goodwin,¹ namely obstructive, embolic, and systemic manifestations. The obstructive manifestations often mimic the pathologic condition of mitral stenosis. Embolization can result in stroke or arterial occlusion.²

In 1954, the first myxoma was excised using cardiopulmonary bypass by Crafoord.³ Since that time, myxomas have been routinely excised with low rates of complications using a variety of atrial approaches. We review our experiences with six patients who underwent surgical resection between 1985 and 1993.

Between May of 1985 and March of 1993, six patients underwent surgical resection of atrial myxomas at Roper Hospital in Charleston, SC, representing approximately 0.3 percent of cardiac operations during that time. The clinical presentations are summarized in Table 1. Pre-operative symptoms included dyspnea in five patients (83 percent), nocturnal dyspnea

specifically in three patients, pulmonary embolism and syncope in one patient each (17 percent). Two patients had developed congestive heart failure (33 percent) and one patient complained of significant angina (17 percent). More remarkable in our experience is the absence of systemic embolization as five of six myxomas were left atrial in origin: and the fact that two patients (33 percent) required two evaluations prior to the diagnosis of atrial

TABLE 1
CLINICAL PRESENTATIONS

Dyspnea	83%
Nocturnal Dyspnea	50%
Syncope	17%
Systemic Embolism	0%
Pulmonary Embolism	17%
Congestive Heart Failure	33%
Edema	17%
Angina	17%
Palpitations	17%
Delayed Diagnosis	33%

*Address correspondence to Dr. Voegelé at 125 Doughty Street, Charleston, SC 29403.

myxoma. Physical findings and laboratory data contributed little to the diagnosis preoperatively. Diastolic rumble or the characteristic "plop" were described in only two patients (33 percent). Electrocardiogram showed left atrial enlargement in four patients (66 percent) and left ventricular hypertrophy in one patient. All patients presented in sinus rhythm. All patients underwent cardiac catheterization and one patient demonstrated critical right coronary artery atherosclerotic occlusion. Two dimensional echocardiography established the diagnosis in all patients, although two patients required reevaluation at one year and one and one-half years respectively, when their physical complaints persisted in spite of originally negative echocardiographic evaluations. One of these patients had his second echocardiographic evaluation done by the transesophageal route.

SURGICAL TECHNIQUE

Atrial myxomas are gelatinous, polypoid, friable tumors with a strong tendency to fragment and embolize. Surgical techniques must be tailored to take that into account. The operations were begun through a median sternotomy, instituting cardiopulmonary bypass, moderate systemic hypothermia, hyperkalemic cardioplegic arrest and topical cooling. Bicaval cannulation was always carried out. Caval tapes were utilized where necessary.

Appropriate atrial incisions were made to approach the tumor from a distance to avoid morcellation and to remove not only the tumor but its area of attachment as well. The right atrial myxoma was resected through a right atriotomy parallel to the interatrial groove. Two patients had only left atriotomy as tumor size and site of attachment were favorable for this approach. Three patients had biatrial approach to the tumor. Two of these were through atriotomy incisions parallel to the interatrial groove, initially at the left atrium and then as a counter incision at the right atrium. The most recent case was performed through a superior transatrial, transseptal approach⁴ (Figure 1). Two patients required patch closure of the sep-



Figure 1. Superior transatrial transseptal approach. (Patient's head is to the left.)

tum. Cold saline irrigation was copiously used following cardiectomy to ascertain absence of any tumor debris prior to atrial closure.

RESULTS

There were no perioperative deaths and no instances of postoperative embolization. The average length of stay in the hospital was 7.6 days. Early morbidity included atrial fibrillation and intermittent junctional rhythm in two patients (33 percent). Nevertheless, all patients were discharged with a sinus rhythm. Late followup revealed one patient dying six years postoperatively of metastatic lung carcinoma. One patient required hospitalization one year postoperatively for paroxysmal atrial flutter, and one patient required pacemaker placement two years following resection for sick sinus syndrome.

DISCUSSION

Benign myxoma is the most common cardiac tumor. Seventy-five percent of atrial myxomas arise on the left and 25 percent on the right. As reflected in our experience, cardiac myxomas occur in women three times more frequently than in men. Presentation can be by valvular obstructive symptoms, systemic or pulmonary embolization, and generalized constitutional symptoms.

Two-dimensional echocardiography is the procedure of choice for establishing the diagnosis. Visualization of the septum can be enhanced by transesophageal echocardiography, essentially eliminating the need for other

TABLE 2
PATIENT CHARACTERISTICS, SURGICAL MANAGEMENT

Age	Gender	Tumor Septal Location	Postoperative Arrhythmias	Surgical Approach
62	F	Right Atrium	Transient Atrial Fibrillation	Right Atriotomy
61	M	Left Atrium	Intermittent Junctional Rhythm	Longitudinal Biatrial
56	F	Left Atrium	0	Superior Transatrial Transseptal
44	M	Left Atrium	0	Left Atriotomy
67	F	Left Atrium	0	Longitudinal Biatrial
65	F	Posterior-Medial Annulus Mitral Valve	0	Left Atriotomy

modalities. However, other modalities have been recommended for unusual or rare presentations. Magnetic resonance imaging, high-speed computed tomography, or levophase angiocardiology have been described as useful.⁶ Aggressive surgical removal is recommended because the operation can be offered with low morbidity and mortality, whereas the sequelae of valvular obstruction or systemic embolization can be potentially devastating. To prevent recurrence, there is widespread agreement regarding complete excision of the base of the tumor.⁵ Discussions dealing with resection of atrial myxomas usually engender some controversy regarding the best approach to these tumors. There are four approaches which can be utilized to yield advantageous exposure:

1. Left Longitudinal Atriotomy: This incision yields the quickest access to the tumor and is advantageous in small sessile or pedunculated masses. It is disadvantageous for handling large and very friable tumors, as one is immediately confronted with the mass upon entry, and fragmentation can then occur.

2. Transseptal Approach Through Right Atriotomy: This incision is begun at the pulmonary vein and taken to the point just caudad to the right atrial appendage. This allows incision of the lateral aspect of the septum toward the upper margin of the foramen ovale. This gives

good access to large masses and is useful for visualizing both atria and ventricles. Reconstruction can be time consuming.

3. Longitudinal Biatrial Approach: In this approach, an initial left atriotomy is performed parallel to the interatrial groove and appraisal of the attachment of the tumor is made. Then a similar parallel incision is made in the right atrium and the stalk excised from the right atrial aspect.

4. Superior Transseptal Transatrial Approach: A more recently used incision begins on the dome of the left atrium and proceeds medial and caudal to the right atrial appendage. The cephalad margin of the interatrial septum is divided toward the upper rim of the foramen ovale, giving a clear view from above to delineate precisely the attachment of the myxoma. This is a useful incision for large friable tumors, particularly when they involve structures other than the septum, such as the mitral valvular apparatus or the zone of entry of the pulmonary veins. Closure can be tedious, but the entire closing anastomosis is clearly visualized and hemostasis can be well ascertained.

CONCLUSION

The diagnosis of atrial myxoma depends in general on the embolic and obstructive manifesta-

tions of the tumor. Transthoracic or transesophageal echocardiographic examination is the diagnostic method of choice and in experienced hands enables precise determination of the tumor's location and attachment. Once the diagnosis has been confirmed, surgery should not be delayed because there is a high risk to life and limb from thromboembolism or valvular obstruction. The simplest, quickest incision to gain access to small left atrial tumors is through an atriotomy parallel to the interatrial groove. Atrial incisions can be tailored to the needs of the patient in terms of tumor location and size or type of stalk attachment. Transatrial transseptal incisions are advantageous for very large friable masses, especially in unusual locations. Excision of the entire tumor with full thickness removal of the stalk attachment assures the patient of remaining free of recurrence. □

REFERENCES

1. Goodwin JF: Diagnosis of left atrial myxoma. *Lancet* 1: 464-467, 1963.
2. Bradham, RR, et al: Aortic obstruction from embolizing cardiac myxoma. *J SC Med Assoc* 75: 7-10, 1979.
3. Crafoord CL: Discussion of Glover RP. The technique of mitral commissurotomy: 172-211, in Lam CR, ed. : *Proceedings of the International Symposium on Cardiovascular Surgery*, Henry Ford Hospital, Detroit, MI, March 1955, Philadelphia: W B Saunders, 202-203, 1955.
4. Kon ND, et al: Mitral valve operation via an extended transseptal approach. *Ann Thor Surg* 55: 1413-1417, 1993.
5. Nasser TK, et al: Cardiac myxoma: The Indiana Heart Institute experience. *Indiana Medicine* 9: 644-647, 1990.
6. Lijor A, et al: Surgical management of intracardiac myxomas, a sixteen year experience. *Texas Heart Inst J* 20: 231-234, 1993.

RECENT DEVELOPMENTS IN ELECTROCONVULSIVE THERAPY

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Electroconvulsive Therapy (ECT) has been in continuous use as a treatment for severe psychiatric illness since its introduction in 1938.¹ As a result of recent refinements in technique, ECT is now more than ever established as an important part of modern psychiatric practice. Its effectiveness approaches 90 percent in properly selected cases² and its side effect profile is acceptable to most patients. The indications for the treatment have become more specific and many medically ill patients are now successfully treated. The American Psychiatric Association's Task Force on ECT has released a consensus document detailing techniques and strategies for the safest and most effective delivery of the treatment.² This paper will review several of these advances and discuss promising areas of ECT research.

INDICATIONS/CONTRAINDICATIONS

The main diagnostic indications for ECT include major depression (both bipolar and unipolar types), mania, and mixed affective states. ECT is also often effective in some cases of schizophrenia when catatonic or prominent affective features are present or when patients have a past history of favorable ECT response.²

In most cases, ECT is prescribed only after a patient fails to respond adequately to psychotropic medications; however, it is used as a first-line treatment in several specific instances: (1) when there is a need for rapid improvement in depression for medical or psychiatric reasons (e.g. malnutrition, catatonia, or suicidality), (2) when the risks of other treatments outweigh the risks of ECT, (3) when the patient has a prior

history of favorable response to ECT, or (4) when the patient prefers to proceed directly to ECT.² More commonly, ECT is prescribed in cases of failure to respond to medications, intolerable side effects to medications, or when a patient's condition deteriorates to a point where a more effective and definitive treatment is required.²

There are no absolute contraindications to ECT and relative contraindications are few. Each patient's level of risk must be assessed individually and weighed against the severity of the psychiatric illness. With suicide rates of major affective disorders approaching 10 to 15 percent,³ the practitioner often makes the decision to treat a medication-refractory patient with ECT despite the presence of medical risk factors. In these cases, modification of ECT technique may minimize conditions of risk.

Some situations associated with increased risk (as outlined in the APA task force report) include: (1) space-occupying cerebral lesion or other cause of increased intracranial pressure, (2) recent myocardial infarction with unstable cardiac function, (3) recent intracerebral hemorrhage, (4) bleeding or unstable vascular aneurysm, (5) retinal detachment, (6) pheochromocytoma, and (7) anesthetic risk rated ASA level 4 or 5.²

CONSENT AND PRE-ECT EVALUATION

Prior to beginning a course of ECT, informed consent should be obtained from the patient and, when possible, the patient's family. Consent is a dynamic process which continues throughout the course of treatment and may be withdrawn by the patient at any time. In cases where informed consent cannot be given by the patient, it should be obtained from those legally

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responsible for the person's medical care, be it the patient's family, guardian or the court system. In the case of maintenance ECT, consent should be renewed at least every six months.²

The pre-ECT evaluation should include medical history, physical exam, family history, psychiatric history (including an evaluation of the adequacy of prior psychiatric treatment) and a mental status exam. The medical workup should include vital signs, hemoglobin and hematocrit, serum electrolytes and EKG. CT or MRI scan of the brain is optional but often useful in ruling out space-occupying lesions and/or increased intracranial pressure. Care should also be given to the fundoscopic exam to rule out papilledema. EEG may also be helpful, as a screening test to detect treatable organic brain disease. Additionally, any point in the patient's history, physical exam, or lab studies which requires further investigation should be pursued aggressively.

As a general rule, all psychotropic medications should be tapered and discontinued prior to ECT. The major exception to this rule is neuroleptic medication, which may be continued through a course of ECT, often at a lower dosage than previously given.² Of particular interest is the need to discontinue lithium approximately three days prior to ECT. It should not be reinitiated until two to three days after the patient's last ECT. This is due to the observation that delirium is more common in patients receiving lithium during a course of ECT. Although the mechanism of this neurotoxic interaction is unknown, one suggestion is that temporary disruption of the blood brain barrier during the seizure leads to increased concentrations of lithium in the CNS.⁴ Other drugs which should be discontinued include theophylline, reserpine, sedative hypnotics, and echothiophate eye drops which irreversibly inhibit pseudocholinesterase and may result in prolonged apnea in patients given succinylcholine.² Benzodiazepines may interfere with the induction of maximally effective seizures and should be avoided when possible.⁵ The risk of giving general anesthesia for ECT to patients taking monoamine oxidase inhibitors continues

to be a subject of discussion.⁶ More research is needed to elucidate the safety and efficacy of other psychotropic drugs when given with ECT. Of particular interest is whether co-administration of antidepressant medications and ECT might actually lead to improved and/or faster antidepressant response.⁷

TECHNIQUE

Prior to each treatment, the patient should have taken nothing by mouth for at least six hours. Exceptions include cardiac or anti-gastric reflux medications given with a sip of water the morning of the treatment. An intravenous catheter is placed and anticholinergic medication (atropine 0.3-0.6 mg im or sc, or 0.4-1.0 mg iv; or glycopyrrolate 0.2-0.4 mg im or iv) is given to prevent bradyarrhythmias. Light general anesthesia is then induced using methohexital (0.75-1.0 mg/kg iv),² and muscle relaxation is achieved with succinylcholine (0.5-1.0 mg/kg iv). One hundred percent oxygen is administered by positive pressure ventilation throughout the procedure. Stimulus electrodes are then placed on the scalp either bilaterally or unilaterally. Bilateral treatment produces the most rapid response, however it may transiently cause more cognitive impairment. Unilateral treatment delivered over the non-dominant hemisphere is associated with less verbal memory impairment, but may not be as effective as bilateral treatment.²

Devices should deliver the electrical stimulus with a brief-pulse, square wave current rather than a sine wave current. Sine wave current has been shown to cause more cognitive difficulty.⁸ Stimulus dosing will be discussed below.

Physiologic monitoring should include EEG, EKG, BP, pulse, and oximetry. In general, patients should be restimulated at a higher stimulus setting if a seizure does not occur or lasts less than 20 seconds. A seizure should be terminated if it persists for more than two minutes by motor criteria or three minutes by EEG criteria. This is commonly done by administering 50 percent of the original methohexital dose. If this fails, benzodiazepines or other agents may be used. Treatments are usually given three times

per week on alternate days in a course of six to 12 treatments. However, this number may vary depending on patient response.

ADVERSE EFFECTS

The nature and probability of adverse effects should be considered individually and discussed as part of the informed consent process. Transient cognitive dysfunction is the most common side effect, manifested by disturbances of orientation and/or memory. These spheres should be assessed prior to ECT and throughout the course of treatment with attention paid to patient self-reports of memory difficulty. If a patient experiences severe cognitive dysfunction, the physician should review the contributions of medications, spacing of treatments, and ECT technique.² Consideration should be given to interruption or discontinuation of the treatment course if modifications are unsuccessful. Other complications, including prolonged cardiovascular dysfunction, prolonged apnea, and prolonged seizures are rare. Transient cardiac arrhythmias occur frequently during, and immediately after, the seizure but usually require no intervention. Headache, nausea and myalgia are common, usually quite benign, and respond to symptomatic treatment.

STIMULUS DOSING

How much electricity should be used to induce the seizure for ECT? This question has become a topic of active research because too little electricity may result in missed or ineffective seizures, while too much electricity may contribute to cognitive side effects. Traditionally, optimal ECT has been defined in terms of the induced seizure, using a defined minimum seizure duration as a criterion for adequate treatment. While it has been proven that a seizure is necessary for the therapeutic effect of ECT, not all seizures are equivalent in producing antidepressant response. Sackeim and colleagues have demonstrated that low-dose right unilateral ECT produces a non-therapeutic seizure. Patients treated with low-dose right unilateral ECT at just above seizure threshold had only a 17 percent response rate compared

to a 70 percent response rate for a group treated with bilateral ECT at just above seizure threshold.⁹ Seizure durations were equivalent between the two groups. Other qualitative aspects of the stimulus and seizure were clearly more important than the seizure duration. Sackeim concluded that the relationship between the individual's seizure threshold and the administered electrical dose was crucial in determining therapeutic response. Further work by the same group has found that higher stimulus dosing (i.e., 2.5 times the seizure threshold) produces more therapeutic right unilateral ECT. Bilateral ECT appears less sensitive to stimulus dosing.⁹ Current data suggest that stimulus dosing for right unilateral ECT should be at least 2.5 times the patient's seizure threshold and just above the seizure threshold for bilateral ECT.

This method requires a determination of the patient's seizure threshold as a requisite to stimulus dosing. This may be done using a "dose titration technique" at the initial ECT session, giving successive incremental stimuli until a seizure is observed (e.g. 12,20,40,80,101.4 static joules on the MECTA SR-2 or 10, 20, 40, 80, 100 percent on the thymatron DGX). The threshold is then taken as the arithmetic mean between the stimulus required for a seizure and the previous, unsuccessful stimulus. This strategy takes on added significance because the seizure threshold varies up to 40-fold from patient to patient.⁹ An individually-tailored stimulus dose can avoid unnecessary cognitive side effects from excessive stimulus in patients with low seizure thresholds. Factors known to increase the seizure threshold include: male gender, increasing age, increased anesthetic dose, anticonvulsant medications, and the anticonvulsant effect of a course of ECT itself.⁹

ANTI-HYPERTENSIVES

Another refinement in ECT technique has been the use of short-acting, intravenous anti-hypertensive medication to attenuate the sympathetically-mediated rise in blood pressure, pulse, and myocardial oxygen demand which accompany a seizure. This is particularly helpful in

patients with a history of hypertension, coronary artery disease, or myocardial infarction.¹⁰ A double-blind, placebo-controlled study of pre-treatment with labetalol, a combined alpha, and beta-adrenergic blocking agent, showed a significant reduction in tachycardia and hypertension, as well as atrial and ventricular arrhythmias, in the labetalol group. The drug produced no untoward side effects or effects on treatment outcome.¹¹ McCall and co-workers also demonstrated the safety and efficacy of labetalol in ECT.¹² Esmolol, an ultra-short-acting beta-1 selective adrenergic blocker, has shown similar cardio-protective qualities in controlled studies.^{13,14} Although most studies have found moderate attenuation of seizure duration with beta blockers, no study has found that these agents decrease the efficacy of ECT. It is recommended that an anti-cholinergic be administered with the beta-blocker to prevent imbalance between the parasympathetic and sympathetic systems during the treatment.¹⁵

PARKINSON'S DISEASE

A growing literature supports the efficacy of ECT in treating the motor symptoms of Parkinson's disease, with or without concomitant psychiatric illness.¹⁶ Since the first clinical reports in 1959, several anecdotal reports have described improvement in bradykinesia, rigidity and postural instability (but less often tremor) in Parkinson's disease patients receiving ECT.¹⁷⁻¹⁹ Swedish clinical trials in the severely disabling "on-off syndrome" have been promising as well, with significant decline in "off" time during a course of ECT.^{20,21} Augmentation of the dopamine system may be a key mechanism leading to response in these patients. Treatment-emergent dyskinesias often develop and halving of the levodopa dose prior to ECT has been recommended.¹⁶ Several groups of investigators are currently developing protocols to more systematically assess the effectiveness and possible mechanism of action of ECT in Parkinson's disease.

MAINTENANCE ECT

ECT is one of the few treatments in medicine

that is commonly stopped once it has proven effective. Clear recommendations are developing for maintenance pharmacotherapy of depression in medication-responsive patients. Common current practice is to place patients on maintenance medication following ECT response. A recent study has found that up to 50 percent of such patients have recurrence of illness at one year.²² These observations support the growing use of ECT as maintenance therapy. Maintenance ECT is typically given as an outpatient treatment at intervals titrated to suppress depressive symptoms. Patients with good support systems are able to come in for a treatment in the morning and return home the same day, following a brief recovery period. Treatments are initially spaced every one to two weeks and then tapered to every one to three months as dictated by the patient's clinical status. A recent review details several small but promising studies of the effectiveness of this mode of maintenance treatment.²³

CONCLUSION

ECT remains an important treatment for serious depression and a limited range of other neuropsychiatric conditions. Refinements in technique allow ECT to be given safely and with an acceptable side effect profile, even in very elderly or medically ill patients. Ongoing research holds the promise of even further reductions in side effects and the eventual elucidation of the mechanism of action of this dramatically effective treatment. □

REFERENCES

1. Cerletti V, Bini L. Un nuovo metodo di shockterapia "l'elettroshock." *Bollettino Accademia Medica Roma*; 64: 136-138, 1938.
2. American Psychiatric Association. *The Practice of Electroconvulsive Therapy: Recommendations for Treatment, Training, and Privileging*. Washington D.C.: American Psychiatric Press, 1990.
3. Kaplan HI, Sadock BJ. *Pocket Handbook of Clinical Psychiatry*. Baltimore: Williams & Wilkins, 1990.
4. Bolwig TG, Hertz MM, Paulson OB, et al. The permeability of the blood-brain barrier during electrically-induced seizures in man. *Eur. J. Clin. Invest*; 7:87-93, 1977.
5. Pettinati HM, Stephens RN, Willis KM, Robin S. Evidence for less improvement in depression in patients taking benzodiazepines during unilateral ECT. *Am J*

- Psychiatry; 147:1029-35, 1990.
6. Kellner CH, Rubey RN, Burns CM, Bernstein HJ, Monroe RR. Safe administration of ECT in a patient taking selegiline. *Convulsive Therapy*; 8(2):144-147, 1992.
 7. Nelson JP, Benjamin L. Efficacy and safety of combined ECT and tricyclic antidepressant drugs in the treatment of depressed geriatric patients. *Convulsive Therapy*; 5:321-329, 1989.
 8. Weiner RD, Rogers HJ, Davidson JR, Squire LR. Effects of stimulus parameters on cognitive side effects. *Ann. NY Acad. Science*; 462:315-325, 1986.
 9. Sackeim HA, Devanand DP, Prudic J. Stimulus intensity, seizure threshold, and seizure duration: impact on the efficacy and safety of electroconvulsive therapy. *Psychiatric Clinics N. Am.*; 14(4):803-843, 1991.
 10. Abrams R. Electroconvulsive therapy in the medically-compromised patient. *Psychiatric Clinics N. Am.*; 14(4):871-885, 1991.
 11. Stoudemire A, Knos G, Gladson M. Labetalol in the control of cardiovascular responses to ECT in high-risk depressed medical patients. *J. Clin. Psychiatry*; 51:508-512, 1990.
 12. McCall WV, Shelp FE, Weiner RD, et al. Effects of labetalol on hemodynamics and seizure duration during ECT. *Convulsive Therapy*; 7:5-14, 1991.
 13. Kovac AL, Goto H, Arakawa K, Pardo MP. Esmolol bolus and infusion attenuates increases in blood pressure and heart rate during ECT. *Can. J. Anesth.*; 37:58-62, 1990.
 14. Howie MB, Black HA, Zvara D, et al. Esmolol reduces autonomic hypersensitivity and length of seizures induced by ECT. *Anesth. Analg.*; 71:384-388, 1990.
 15. Abrams R. *Electroconvulsive Therapy*, 2nd edition. New York: Oxford University Press, p. 85, 1992.
 16. Rasmussen K, Abrams R. Treatment of Parkinson's Disease with ECT. *Psych. Clin. N. Am.*; 14(4):925-933, 1991.
 17. Fromm GH. Observation of the effects of electroshock treatment in patients with parkinsonism. *Bulletin of Tulane Univ.*; 18:71-73, 1959.
 18. Lebensohn ZM, Jenkins RB. Improvement of parkinsonism in depressed patients treated with ECT. *Am. J. Psychiatry*; 132:283-285, 1975.
 19. Yudofsky SC. Parkinson's disease, depression, and ECT: a clinical and neurobiologic synthesis. *Compr. Psychiatry*; 20:579-581, 1979.
 20. Balldin J, Eden S, Granerus AK, et al. ECT in Parkinson's syndrome with "on-off" phenomenon. *J. Neural. Transm.*; 47:11-21, 1980.
 21. Andersen K, Balldin J, Gottfries CG, et al. A double-blind evaluation of ECT in Parkinson's Disease with "on-off" phenomenon. *Acta Neurol. Scand.*; 76:191-199, 1987.
 22. Sackeim HA, Prudic J, Devenand D, et al. The impact of medication resistance and continuation pharmacotherapy on relapse following response to ECT in major depression. *J. Clin. Psychopharm.*; 10:96-104, 1990.
 23. Monroe RR. Maintenance electroconvulsive therapy. *Psych. Clin. N. Am.*; 14(4):947-60, 1991.

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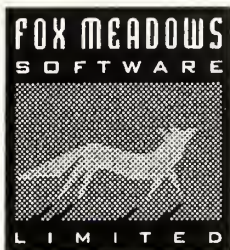
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ERRATUM

The January 1995 Cover Contents contained the topic "Child and Adolescent Psychology." This should have read "Child and Adolescent Psychiatry," referring to the article which appeared beginning on page 5 entitled "Current Child and Adolescent Inpatient Psychiatric Treatment - Evolution or Regression?" by Donald J. Carek, M. D., and Lisa D. Hand, M. D. The Editorial Staff of *The Journal of the South Carolina Medical Association* regrets this error and offers apologies to the authors.



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Memo

To: **President Clinton
Members of the House and Senate**

From: **The 300,000 member physicians of the
American Medical Association**

Re: **Getting the job done on health care**

We believe there are several workable measures that can be passed now to help achieve our ultimate goal – making quality health care affordable and accessible to all Americans.

As the country awaits the State of the Union address, the member physicians of the American Medical Association set forth these practical recommendations to improve health care for our patients.

Insurance Reform – Pass insurance reforms that will make sure Americans will not lose their coverage if they change jobs or get sick.

Medicare Reform – Reform our Medicare system so it will be there for the next generation of elderly and disabled.

Medical Savings Accounts – Make MSAs available so people can pay for routine medical care with pre-tax dollars.

Patient Protections – Enhance patient choice, disclosure and assure greater physician involvement in corporate decisions about patient care.

Liability Reform – Enact meaningful liability reform to ensure fair compensation to patients with legitimate claims while eliminating excessive malpractice awards that lead to defensive medicine.

Regulatory Relief – Free both physicians and patients from the ever-increasing burden of needless and wasteful paperwork, regulations, obsolete anti-trust rules and red tape.

Medical Education and Research – Protect medical education and research so that we can find cures for killers like AIDS and cancer.

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These measures are sensible things we can do now that will make a difference for all of us. So, as we begin our nation's 104th Congress, we renew our pledge to the health of America. As the voice of the medical profession, we pledge to do everything we can to help make these things happen. It is our contract with America, and we fervently hope that every American will join us.

American Medical Association
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SCMA NEWSLETTER

A PUBLICATION OF THE SOUTH CAROLINA MEDICAL ASSOCIATION

Joy Drennen, Editor

798-6207, in Columbia

Contributions welcomed

1-800-327-1021, outside Columbia

March 1995

MEDICARE UPDATE

The March, 1995 *Medicare Advisory* has been mailed. Included in this *Advisory* is a list of tests authorized by the CLIA program for Waiver or Physician Performed Microscopy Procedures (PPMP) certificates, as well as other useful information.

HCFA Clarification on Breast Biopsy and Mastectomy Performed on the Same Day: The rebundling instructions bundle breast biopsy into payment for a mastectomy. There has already been a confirmed diagnosis of malignancy that has precipitated the mastectomy, and the biopsy done on the day of the surgery is part of the mastectomy. Payment for the biopsy (or biopsies) is included in the payment for the mastectomy and no additional payment for the biopsy or biopsies will be made.

However, when the breast biopsy and mastectomy are performed on the same date and the purpose of the biopsy is to determine if there is a malignancy before proceeding with the mastectomy, Medicare will pay for both the mastectomy and the biopsy. Add the following modifiers to the CPT code:

- Modifier -58 that the biopsy is a staged procedure, and
- Modifier -51 to indicate that it is a multiple procedure.

While both codes would be allowed and paid, the multiple surgery reductions apply to these services.

Interest Rate Correction: In the February, 1995 "SCMA Newsletter," we inadvertently published an old interest rate. The new interest rate for overpayments and underpayments is 13.625 percent effective January 6, 1995.

There is a separate interest rate which applies to Medicare claims not paid on a timely basis. Effective January 1, 1995, the rate is 8.125 percent. See the March *Advisory* for additional information.

Railroad Retirement Benefits: Travelers Insurance Company, the insurance carrier for the Medicare Part B portion of the Railroad Retirement Program, has changed its name. The correct name is **MetroHealth**. Claims for RRBs should be submitted to MetroHealth, RRB Medicare Claims Office, PO Box 10066, Augusta, GA 30999, (706) 855-1386.

Medicare Secondary Payer Service Center: In order to provide the most efficient service possible, Medicare will merge the Medicare Secondary Payer (MSP) telephone service into Medicare Part B Provider Service Center beginning April 1, 1995. Customer Service Representatives are currently training on MSP issues so that they will be prepared to handle your questions beginning April 1. □

CHARGES FOR CLIA CERTIFICATION

Physicians who are certifying or recertifying their labs under CLIA requirements should call the Commission on Laboratory Accreditation (COLA) at (800) 298-8044. We have indications that COLA charges are significantly lower than DHEC charges.

MEDICAID UPDATE

Medicaid Billing Workshops: The Department of Physician Services offers basic billing workshops on a quarterly basis in Columbia. The workshops are geared toward new billing staff and new providers in the Medicaid program. Workshops are scheduled for Wednesdays on May 3, August 2 and November 2, 1995, from 12:30 pm to 3:00 pm at the Jefferson Square Plaza. *For more information and to register for a workshop, please call the Department of Physician Services at (803) 253-6134. The workshops are free!*

PROs DIRECTED TO CEASE ATTESTATION REVIEW

Effective immediately, the PROs are not required to perform review of the attestation document as specified in section C.3.3.10 of the current S.O.W. and in section C.3.3.11 of the streamlined S.O.W. (dated July 1, 1995). In a memo to Carolina Medical Review (CMR), the director of the Office of Quality Improvement Programs stated that the Medicare-Technical Advisory Group's (M-TAG's) Beneficiary Protection and Documentation Task Force recommended that the attestation requirements at 42 CFR 412.46 be changed to shift responsibility from the physician to the hospital for accurately reporting diagnoses and procedures relating to DRG classification under the Medicare hospital prospective payment system. Until such time as the 42 CFR 412.46 requirement is modified, it remains in effect; however, CMR will no longer be monitoring compliance. Attestation documents continue to be a required part of the medical record and are necessary for DRG validation review. Please continue to include an official attestation document when records are requested for review. HCFA will be issuing the formal policy regarding attestations in the near future.

MAKE SURE THEY'RE COVERED

Do you provide immunizations for children, seniors or immunocompromised patients? If so, the AMA has a deal for you.

A free, up-to-date packet of immunization information is now available through a new AMA-staffed clearinghouse. It's free to all physicians and other health care providers who give immunizations; you don't have to be an AMA member. Even the phone call to the "Make sure they're covered" program is free. The clearinghouse is underwritten by a grant to the AMA from the Centers for Disease Control and Prevention as part of its Childhood Immunization Initiative. Physician involvement is vitally important to increasing immunization. Infants are especially at risk. Now is an especially good time to update yourself, because changes are taking place that may affect your patients.

Perhaps the best-known development is the fledgling Vaccines for Children program, or VFC which was launched in October of last year. It provides federally funded vaccines for poor and uninsured young people through state-run programs. The packet includes information on the program and about how physicians can sign up to participate. Of special interest to physicians who treat young people will be the revised immunizations schedule for infants, children and adolescents, and a 21-page CDC "Guide to Contraindications to Childhood Vaccines." Both are included. As of October 1, 1994, the government requires physicians to provide patient information material whenever immunizations are given. The AMA packet includes information sheets which can be photocopied and distributed to your patients.

In addition, the packet contains a summary of vaccines in development, information about vaccinations for older adults and immunocompromised patients, a fact sheet on the National Vaccine Injury Compensation Program, titles of articles about immunizations and a list of useful telephone numbers. Additional information on specific vaccines is available by fax from the CDC or the AMA.

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PALMETTO HEALTH INITIATIVE HOTLINE

Question: How will managed care in South Carolina affect rural health clinics in regards to reimbursement? (James L. Bland, MD, Aiken)

Answer: Currently, the Health and Human Services Finance Commission is including rural health clinics (RHCs) in the Palmetto Health Initiative (PHI). Consequently, RHCs would lose their current reimbursement rates and would start receiving the rates established under the PHI just like any other provider.

PHI consists of two types of managed care plans, the Capitated Access Program (CAP) and Physicians' Enhanced Program (PEP). Under CAP, a fully capitated program covering most Medicaid services, the Medicaid recipient will be enrolled in an HMO and will choose a participating physician in that HMO. The HMO will pay physicians and other health care providers according to whatever rates they set for the services rendered. Under PEP, a partially capitated program covering primary care services, the Medicaid recipient will choose one physician to serve as a "gatekeeper" from a list of physicians participating in PEP in their area. The Finance Commission will pay physicians a monthly capitated rate for each recipient enrolled in your practice. These capitated rates have not been released by the Finance Commission.

Currently, RHCs are paid an all-inclusive rate using the Medicare RHC rate. RHC's rates are capped at the Medicare rate for rural health centers. At the end of the year, a settlement is completed. Although RHCs would lose this method of payment under PHI, they may not be adversely affected if the capitated rates are adequate. The SC Rural Health Clinic Association is represented on the PEP Advisory Committee. The PEP Advisory Committee was convened by the Finance Commission last year to review the services in the package and other details of the program. This committee will reconvene to review the capitated rates once they are released.

Question: Will AIDS patients be included in the Palmetto Health Initiative? (William Davis, MD, Myrtle Beach)

Answer: AIDS patients will be covered in the Palmetto Health Initiative as any other patient. Although AIDS/HIV patients' office visits are included in the monthly capitated rate for the PEP program, there are home and community based services available for AIDS/HIV patients which will be reimbursed fee-for-service. These services include private duty nursing, personal care aide services, home delivered meals, counseling services, foster care services, case management, and modified hospice services.

Comments: I firmly believe that Hospice services should be included in the Palmetto Health Initiative. (Chris Brunson, MD, Charleston)

Please call the Palmetto Health Initiative Hotline (1-800-825-8921) with your questions regarding the Medicaid waiver. ☐

SCMA ANNUAL MEETING

April 20-23, 1995
Charleston, SC

The 147th Annual Meeting of the South Carolina Medical Association will mark 15 consecutive years in Charleston and the ninth consecutive year at the Omni Hotel.

Information regarding the meeting, including registration form and hotel reservation form, has been mailed to all South Carolina physicians, but if you have not received this information, you may use the registration form on this page, or call SCMA Headquarters in Columbia (798-6207 or 1-800-327-1021). Again, there is no registration fee for SCMA members, and pre-registration is encouraged.

The House of Delegates meets to consider the business of the association on Friday, April 21, and again on Sunday morning, April 23. Reference Committees will meet on Friday afternoon.

A total of 14 AMA Category 1 and 14 AAFP Prescribed hours have been approved for scientific sessions beginning on Wednesday afternoon and continuing through Saturday afternoon. Special guests for this annual meeting include Richard F. Corlin, MD, Vice Speaker of the AMA House of Delegates.

Again this year, the SCMA will serve as the umbrella organization for many specialty societies who will hold business and scientific sessions during the Annual Meeting.

The SCMA Board of Trustees will meet on Thursday, April 22 and at breakfast each day to consider business which arises during the House of Delegates meeting.

The April issue of *The Journal* will contain reports and resolutions available at publication deadline. Additional reports and resolutions received after the April issue goes to press will be included in the delegates' handbooks which will be mailed prior to the meeting. Delegates are asked to bring their handbooks to the meeting or to pass them along to alternate delegates if they are unable to attend. ☐

CAPSULES

Colin W. Howden, MD, Columbia, has been appointed to the Editorial Board of *The Journal* as a representative of the Young Physicians Section.

! REGISTER TODAY ! SCMA ANNUAL MEETING

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EVALUATION OF COMPUTERIZED ELECTROCARDIOGRAPHIC INTERPRETATIONS IN A COMMUNITY HOSPITAL*

WILLIAM W. PRYOR, M. D.**

DAWN W. BLACKHURST, M. S.

KATHY GATES

GALEN S. WAGNER, M. D.

Computerized electrocardiographic (ECG) analysis systems are commonly used as the initial screening step in clinical interpretation of ECGs. The second step involves confirmation by a physician. In community hospital settings, over-readings may be performed by cardiologists or internists. Requirements to qualify for this privilege may vary by institution and the experience of the physicians available. In some hospitals the privilege to interpret ECGs is restricted to a limited number of physicians, while other institutions have an "open staff" policy. Computer analysis facilitates the interpretation of ECGs but is not a substitute for evaluation by a physician.

The data contained in this report were gathered as part of a quality assurance study to evaluate how well the two-step "overreading" method functions in a community hospital. The purposes of the investigation were two: first, to determine, by physician over-reading, the rate of discrepancy with computerized ECG interpretations; and second, to classify the discrepancies according to clinical significance (Table I) and type of abnormality.

METHODS

A total of 619 ECGs recorded on adult patients

were evaluated. The non-consecutive sampling periods occurred during three months in 1991 and four months in 1992. Each sampling period varied from one to five days, during which 50 to 100 consecutive ECGs were selected for the study. The reviewer (first author) over-read all records independently, and his interpretations were used as the "reference standard" for comparison purposes. Two hundred ninety ECGs (47 percent) were interpreted as normal by computer, physician, and reviewer; these normal recordings were excluded from the study. From the remaining 329 abnormal recordings a 33 percent random sample of 111 was selected for additional review by a validating specialist (fourth author) to corroborate the reviewer's interpretations. The validating specialist was blinded to the diagnostic interpretations of both the physician and the reviewer.

Greenville Memorial Hospital (GMH) is a 676-bed tertiary care community teaching hospital located in Greenville, South Carolina. More than 100 ECGs are recorded throughout the hospital and outpatient facilities each day using Marquette SL carts. Processing of the records, including editing reports, storage, and retrieval, was accomplished with a Muse System in a central ECG department. All computer interpretations are confirmed by a physician before the report is considered final and made a part of the patient's record. Computer reports include the patient's age and sex, time and location recorded, and computer interpretation with reference to any previously stored ECG. When available, a maximum of two previous

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TABLE 1
DESCRIPTION OF SEVERITY CODES FOR DIAGNOSTIC DISCREPANCIES

Grave Error	Could result in improper diagnosis, management, and adverse clinical result — may be life threatening
Major Error	Could result in improper clinical diagnosis or management and cause adverse clinical result, but NOT life threatening
Minor Error	Change in ECG interpretation, but unlikely to significantly alter clinical management or results

ECGs were attached to the most recent record for comparison. Photocopies of confirmed records were made available to the reviewer.

Diagnostic interpretations of all recordings, severity of discrepancies, and type of cardiac abnormalities were coded by the reviewer. Codes for the severity of diagnostic discrepancies (none, minor, major, or grave) are described in Table 1. For those records classified as "grave," a retrospective review of the patients' charts was completed by the reviewer in order to obtain follow-up clinical information and diagnoses.

Descriptive terms used in this report for the types of reviewers are "computer," "staff physician," "reviewer," and "validator." Staff physicians over-reading the study sample included 22 internists, both generalists and subspecialists, and 12 board-certified cardiologists, all of whom were assigned from the hospital's ECG roster during the study period. The minimum requirements to obtain the privilege to interpret ECGs at GMH include (1) evidence of residency training sufficient for board eligibility in internal medicine and (2) documentation of competence in ECG interpretation. Physicians holding privileges prior to 1988 were "grandfathered."

The reviewer is a board-certified cardiologist with a special interest in electrocardiography, including teaching medical students and residents ECG interpretation. He holds faculty appointments at both medical schools in the state.

The validator is a board-certified cardiologist who has taught electrocardiography for 25 years. He is an associate editor of the *Journal of Electrocardiography*, a charter member of the International Society of Computerized Electrocardiography, and author of several electrocardiographic texts.¹⁻³

All data analyses were performed using SAS statistical software (SAS Institute, Inc., Cary, NC). Differences in proportions were evaluated using the chi-square test for homogeneity. $P < 0.05$ was considered as representing conventional statistical significance.

RESULTS

Rates of diagnostic discrepancies between staff physicians and computerized ECG interpretations are presented in Table 2. In the total sample of ECGs with discrepancies (Table 2A) staff physicians disagreed with the computer in only 25 percent of the records reviewed. This rate was significantly lower than the reviewer's discrepancy rate of 45 percent ($p < 0.001$). When staff physicians were subdivided into cardiologists and internists, no significant difference in overall discrepancy rates was found; therefore, these two groups of physicians were combined for all other analyses.

In the sub-sample of records ($N=111$) examined independently by the validating physician (Table 2B), the discrepancy detection rate for staff physicians was 17 percent, compared to 41 percent and 38 for the reviewer and validator, respectively. No significant difference in rates was found between the reviewer and validator ($p=0.38$).

Of the 329 abnormal records, the reviewer disagreed with the computer interpretation in 148. The clinical significance of these disagreements ranged from minor to grave (as defined in Table 1). Of the 148 disagreements, 94 (63.5%) were classified as minor, 42 (28.4%) as major, and 12 (8.1%) as grave, or potentially life-threatening. Examples of the minor category include disagreements related to the presence or absence of premature atrial beats vs.

TABLE 2
DETECTION RATE OF ERRORS (OR DISCREPANCIES) IN COMPUTERIZED ECG INTERPRETATIONS
BY TYPE OF PHYSICIAN

Type of Physician	No. ECGs Reviewed	No. (%) Discrepancies With Computer Diagnoses
A. TOTAL SAMPLE OF ECGs WITH DISCREPANCIES		
Staff Physicians	329	83 (25.2)
—Cardiologists	141	39 (27.7)
—Internists	188	44 (23.4) ⁺
Reviewer	329	148 (45.0) [†]
B. RANDOM SAMPLE FOR VALIDATION		
Staff Physicians	111	19 (17.1)
Reviewer	111	46 (41.4)
Validator	111	42 (37.8) ^{‡‡}

+ P = 0.38 for cardiologists versus internists.

† P < 0.001 for reviewer versus staff physicians.

‡‡ P = 0.58 for validator versus reviewer.

sinus arrhythmia, supraventricular ectopic beats with aberrancy vs. ventricular ectopic beats, voltage criteria, interval duration, axis, and minor ST-T changes.

Of the 42 records considered to reflect major discrepancies, 26 (62%) involved the diagnosis of myocardial infarction and/or ischemia, nine (21%) related to A-V conduction abnormalities and/or atrial arrhythmias, and six (14%)

involved right ventricular hypertrophy, pre-excitation, electronic pacing, and limb or precordial lead reversal resulting in improper diagnoses.

The 12 records categorized as having grave discrepancies are listed in Table 3. Seven of these 12 had previous ECGs and/or clinical information (over-reading physician same as ordering physician) available. In 11 of the 12 records with grave discrepancies, follow-up clinical diagnoses obtained from the patients' charts supported the reviewer's interpretations.

Rates of discrepancies by severity code for staff physicians versus reviewer are displayed in Figure 1. Staff physicians identified 37 percent of the minor and 74 percent of the major discrepancies, but only three of the 12 (25%) in the grave category. Of the 148 discrepancies detected by the reviewer, the majority (55 or 37%) involved the diagnosis of myocardial infarction and/or ischemia.

Staff physicians detected 49 percent of these and 81 percent of discrepancies involving arrhythmias, but only 28 percent of those related to hypertrophy.

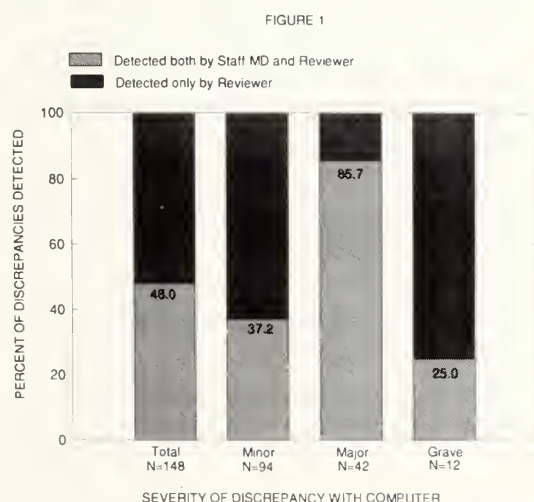


Figure 1. Percentage of discrepancies with computerized interpretations by type of physician ("staff MDs" – cardiologists or internists – versus a reviewer), and by clinical severity of discrepancy.

DISCUSSION

The two-step method of ECG interpretation was initiated at GMH approximately eight

TABLE 3
DETAILED DESCRIPTION OF 12 "GRAVE" DISCREPANCIES

Pt. No.	Computer Diagnosis	Staff MD Diagnosis	Reviewer Diagnosis
1	Normal	✓	ST-T abn c/w inferior injury
2	Normal	✓	ST-T abn c/w acute anterior injury
3	LAE, IVCD Borderline	✓✓	ST-T abn, anterior ischemia
4	NS ST-T abn.	✓	Abn. ST-T c/w anterior injury
5	SAT, abn. LAD Borderline	✓✓	Hyperkalemia
6	WPW	✓✓	WPW ST-T chg, acute inferior injury
7	NS-ST abn.	✓	Possible ASMI, age undetermined
8	LAD, LBBB	✓✓	ASMI recent, intermittent LBBB
9	LVH, NS-ST abn.	✓	ASMI, possibly acute, LVH
10	SR, PAC, LBBB	✓	2:1 AV Block, ASMI, age undetermined
11	NS ST-T abn.	✓✓✓	ST-T abn. cw injury
12	Normal	✓	ST-T abn. c/w acute anterior injury

✓ Staff physician agreed with computer diagnosis.

✓✓ Staff physician agreed with reviewer.

✓✓✓ Staff physician disagreed with computer's and reviewer's diagnoses.

See Appendix A for all abbreviations used in Table 3.

years ago to address the need for readily available reports, especially for emergency room and preoperative patients. Although there was concern about reliance on unconfirmed computer reports, the physicians responsible for instituting the system considered it satisfactory. There was a consensus that if a record was reported "normal," the probability of not recognizing a serious problem (e.g., acute myocardial infarction) was very unlikely.

Numerous published reports evaluating the accuracy of computer interpretation of ECGs are available.^{4,13} In a study by Willems et al.,⁴ computer analyses were compared to clinically validated diagnoses of certain cardiac disorders (ventricular hypertrophy and myocardial infarction); an accuracy rate of 69.7 percent was reported. This rate compared favorably with the cardiologists' rate of 76.3 percent. The authors concluded that "some, but not all computer programs performed almost as well as cardiologists" in this limited number of disorders.

Another report, from an outpatient teaching facility, described the level of competency of ECG interpretation by family practice physicians aided by the computer.⁵ The family physi-

cian readings were compared to those of a consulting cardiologist and an electrocardiographer, who was used as the "gold standard" for definitive comparison. This study indicated that the family practice physicians correctly identified 67 percent of potentially significant findings. However, when these practitioners over-read computer-interpreted records, this rate increased to 88 percent, which closely approximated the 91 percent achieved by the consulting cardiologist. The authors recommended the use of computerized ECG interpretation because of the availability of immediate results.

Experience at GMH revealed that in the majority of cases the preliminary computer analyses were accurate and quite useful. However, over time, serious discrepancies began to be reported. Physicians noted that it was not unusual to see a computer report of "normal ECG" when the physician over-read indicated a major abnormality, and vice versa. Ordering physicians who were often dependent on preliminary computer reports began to question the diagnoses and insisted on more timely confirmation. It was in this context that the present study was initiated.

Results from this study revealed that 54

(8.7%) of the 619 ECGs reviewed contained major or grave discrepancies which were undetected by the computer. Thirty-three of these (61%) were recognized by the staff physician upon review. Although the majority of discrepancies were detected by cardiologists or internists on initial over-read, this study indicates that the two-step method at GMH needs improvement. Of particular concern are the ECGs determined normal by computer analysis that proved to have abnormalities indicative of major or grave importance.

The 12 ECGs in the grave category included five interpreted as normal or borderline by the computer. In three of these, the staff physician agreed with the computer. Non-specific ST-T abnormalities described in four patients proved to be changes indicative of early myocardial injury. The ECG with changes of hyperkalemia was interpreted as borderline with abnormal LAD. The computer diagnosis of WPW in ECG #6 did not include any reference to atypical ST-T changes.

Although we were unable to determine whether staff physicians reviewed previous ECGs, we find it more difficult to explain the apparent lack of influence of clinical information assumed to be available if the ordering and reading physician were the same. Speculation would certainly suggest the overreader just "signed-off" on the report in many of these. It is reassuring that the clinical management does not appear to have been adversely affected by the computer diagnoses with the possible exception of cases #2 and #11 (Table 3). Patient #2 may have followed medical advice for admission in the emergency room if told his ECG was abnormal. He returned three hours later with evidence of acute myocardial infarction. Although admitted to the CCU, the early management of patient #11 might have been different if the ECG abnormalities had been appreciated.

The uncertainty caused by inaccurate computer interpretations has prompted some physicians to suggest deleting this information. However, a better solution might be improvement of the two-step method. Suggestions for possible

changes include: (1) perform regular quality assurance to assess problems related to technique; e.g., artifact or improper lead placement with appropriate follow-up and in-service training for technicians; (2) provide clinical information from the ordering physician; (3) establish a "call back" system that requires the over-reading physician to notify the ordering physician of any change in interpretation indicating a need for urgent clinical evaluation; (4) periodically review the format of the ECG recordings, emphasizing provision of previous records; and (5) increase the qualifications required of physicians reading ECGs of patients for whom they have no clinical responsibility.¹⁴ Requiring satisfactory performance on a recognized competency examination would not be unreasonable for non-cardiologists.

Hospitals with an "open staff policy" should consider adding a "third step," one similar to the method used in the present study. Computer interpretations and physician over-readings would be followed by the review of appropriate samples of records by a physician with expertise in electrocardiography; the primary objective would be to identify individuals with an unacceptable level of performance.

Competency alone will not necessarily guarantee that a physician will render accurate interpretations. There must be interest and willingness to devote the necessary time to review all tracings carefully. The argument against competency exams is in large part based on this premise. However, without an appropriate level of competency, no amount of dedication of time or effort is likely to provide acceptable performance of ECG interpretation. An "open staff policy" increases the difficulty of assuring consistency and accuracy.

The results of this study, with recommendations for changes, have been presented to the GMH Department of Medicine and Officers of the Medical Staff. The response was mixed: acceptance that a problem exists, but reluctance to make changes that might restrict privileges without a follow-up quality assurance study examining individual performance. As a result, the "third step" has been added at GMH for

quality assurance of ECG interpretation.

SUMMARY

Electrocardiography is a readily available and relatively inexpensive diagnostic aide for the evaluation and management of many patients. The addition of computer analysis now provides a recording complete with an interpretation. Unfortunately, these interpretations are not always accurate, and physicians should be aware that tracings interpreted as normal may in fact mask serious clinical abnormalities. On the other hand, an ECG with a computer diagnosis of clinical importance – e.g., major myocardial infarction – may in fact be normal. This study was undertaken to (1) determine the rate of discrepancies between computer-interpreted ECGs and over-readings by staff physicians and a reviewer and (2) make recommendations for improving the quality of ECG management and reporting in community hospitals.

Results indicate that the reviewer detected a higher percentage of discrepancies than did staff physicians. In 54 of the 619 ECGs (8.7%), these discrepancies were major or grave. The over-reading staff physician recognized 86 percent of the major, but only 25 percent of the grave discrepancies. These findings indicate a need for confirmation of all computer interpretations by physicians not only competent in electrocardiography, but also committed to taking extra time and effort to render accurate reports. The temptation to just “sign off” on a tracing should not be acceptable, especially when there is close to a one in 10 chance that a significant error in interpretation will be missed. □

ACKNOWLEDGEMENTS

The authors would like to acknowledge the contributions of Rosemary Johnson, Chief Technician of Electrocardiography, and Sheila Rogers, of the Cardiology Laboratory at Greenville Memorial Hospital, for collection and organization of the EKGs used in this study. We would also like to acknowledge Nancy D. Taylor, Ph. D., Medical Editor, for editorial expertise in the preparation of this manuscript.

REFERENCES

1. Margolis JR, Wagner GS. Coronary Care: Arrhythmias in Acute Myocardial Infarction. (Dallas, TX): American Heart Association, 1976.
2. Wagner GS, Waugh RA, Ramo BW, eds. Cardiac Arrhythmias. New York: Churchill Livingstone, 1983.
3. Marriott JHL, Wagner GS (collaborative ed). Practical Electrocardiology. 8th ed. Baltimore: Williams & Wilkins, 1988.
4. Willems JL, Abreu-Lima C, Arnaud P, Van Bommel JH, Brohet C, Degani R, et al. The diagnostic performance of computer programs for the interpretation of electrocardiograms. *N Engl J Med* 325:1767-73, 1991.
5. Woolley D, Henck M, Luck J. Comparison of electrocardiogram interpretations by family physicians, a computer, and a cardiology service. *J Fam Pract* 34(4):428-32, 1992.
6. O'Rourke MF, Cook A, Carroll G, Gallagher D, Hall J. Accuracy of a portable interpretive ECG machine in diagnosis of acute evolving myocardial infarction. *Aust NZ J Med* 22:9-13, 1992.
7. Drazen E, Mann N, Borun R, Laks M, Bersen A. Survey of computer-assisted electrocardiography in the United States. *J Electrocardiol* 98-104, 1988 (Supp).
8. Willems JL, Arnaud P, Van Bommel JH, Bourdillon PJ, Brohet C, Volta SD, et al. Assessment of the performance of electrographic computer programs with the use of a reference data base. *Circulation* 71:523-34, 1985.
9. Willems JL, Arnaud P, Van Bommel JH, Bourdillon PJ, Degani R, Graham I, et al. Development of a reference library for multi-lead ECG measurement programs. *J Electrocardiol* 56-61, 1987 (Supp).
10. Bailey JJ, Itscoitz SB, Hirshfeld JW, Grauer LE, Horton MR. A method for evaluating computer programs for electrocardiographic interpretation. I. Application to the experimental IBM program of 1971. *Circulation* 50:73-9, 1974.
11. Pipberger HV, Cornelfeld J. What ECG computer program to choose for clinical application. The need for consumer protection. *Circulation* 47:918-20, 1973.
12. Brohet CR, Richman HG. Clinical evaluation of automated processing of electrocardiograms by the Veterans Administration program. *Am J Cardiol* 43:1167-74, 1979.
13. Jakobsson A, Ohlin P, Pahlm O. Does a computer-based ECG-recorder interpret electrocardiograms more efficiently than physicians? *Clin Physiol* 5:417-23, 1985.
14. Blake TM. Who is qualified to interpret electrocardiograms? *South Med J* 78(4):368-70, 1985.

APPENDIX A

Abbreviation	Definition
abn	Abnormality
ASMI	Anteroseptal myocardial infarction
AV	Atrioventricular
chg	Change
c\w	Consistent with
IVCD	Interventricular conduction delay
LAD	Left axis deviation
LBBS	Left bundle branch block
LVH	Left ventricular hypertrophy
NS ST-T abn.	Non-specific ST-T Wave abnormality
PAC	Premature atrial contractions
LAE	Left atrial abnormality or enlargement
SR	Sinus rhythm
SAB	Sinus brachycardia
SAT	Sinus tachycardia
WMA	Wall motion abnormality
WPW	Wolf Parkinson White Syndrome

DIGOXIN DOSING: AN ALTERNATE APPROACH*

KELLY W. JONES, PHARM. D.**

RICHARD R. HOWELL, M. D.

Therapeutic drug monitoring can be an important part of the management of drugs with narrow therapeutic margins, especially those with potentially serious side effects.¹ The proper timing of therapeutic drug monitoring is important in order to correctly assess the significance of the level.² Unfortunately the timing of the drug level is frequently overlooked by the physician.³

Digoxin is a drug that may require therapeutic monitoring. It has a narrow therapeutic margin, is frequently prescribed, and may have serious side effects, especially in the elderly and patients with impaired renal function.⁴ In 1991 digoxin was the fourth most frequently prescribed drug nationally and the most frequently prescribed cardiovascular drug.⁵

The purpose of this study was to determine if physicians in a family medicine residency program checked digoxin levels appropriately.

METHODS

The study was conducted over a 17-month period in a community-based family medicine residency program with 21 resident and four full-time faculty physicians. At the time the digoxin level was obtained, the laboratory technician recorded the following information: physician, date, time the patient reported taking the last dose, and time the level was obtained. Only levels with complete information were included in the study. Drug levels were determined by radioimmunoassay. The therapeutic serum concentration was 0.7 – 2.0 ng/ml. The timing of the drug level was evaluated as appropriate if it was performed at least eight hours after the last dose of digoxin. Only the authors and the labo-

ratory technicians were aware of the study.

RESULTS

There were 105 levels performed during the study period, 45 of these had complete information. Sixty levels were excluded: nine were due to the patient's failure to remember the last dose, 51 were due to the technician's failure to record complete information. Thirty-three of the 45 levels were performed at incorrect times.

DISCUSSION

The results of the present study suggest that these family physicians were unaware of the appropriate time to perform digoxin levels. Several other authors⁶⁻¹¹ have noted the same results. Proper timing of digoxin levels is founded on an understanding of the pharmacokinetics of digoxin. There are two stages of its distribution.² First is the rapid distribution of digoxin into the tissues. Second is the steady state which reaches a plateau at about eight hours after the dose. The optimal time for drug levels is after the steady state is achieved.¹ Levels drawn during the distribution phase may be falsely elevated.

Since it is convenient to draw blood samples when the patient visits the physician's office, it seems appropriate to dose digoxin in the evening instead of the morning. Dosing in the evening permits the eight-hour distribution phase, and levels can be accurately monitored any time the next day. Others^{10,12} have suggested evening dosing of digoxin. Alvisi¹² found that evening dosing optimized bioavailability and increased levels. Dobbs¹³ examined the optimal time to perform digoxin levels with regard to the half-life of the drug. Consideration of drug half-life allows for patient variability, e. g., a patient with renal insufficiency. These results showed that patients with impaired renal function had drug half-lives ranging from 15-100

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hours, but they had a common point of intersection at 11 hours of distribution. Evening dosing allowed for this interval and permitted accurate digoxin monitoring the next day. Radja¹⁴ showed that patients actually tolerated digoxin better when dosed in the evening.

Digoxin levels are not usually performed in a vacuum removed from the patient and must be interpreted based on clinical information from the patient. The physician must correlate the digoxin level with the desired clinical effect of the drug. Some patients may have subtherapeutic drug levels but have the desired clinical effect of the drug. An inappropriately timed level, however, may confuse the interpretation of the result and complicate the decision-making process.

To facilitate the proper timing and interpretation of serum levels, digoxin should be administered in the evening rather than the morning. Matzuk³ found that 26 percent of digoxin levels were performed at inappropriate times. After changing the dosing time from 9:00 AM to 5:00 PM, only six percent of digoxin levels were performed inappropriately. Subsequent to this study our hospital changed all dosing of digoxin from the morning to the evening.

CONCLUSION

The pharmacokinetics of digoxin dictate that the optimal time for a serum level is after the steady state is achieved, i. e., eight hours after the dose. The evening administration of digoxin allows for the eight hour distribution phase and permits the appropriate monitoring of digoxin levels anytime the following day. □

REFERENCES

1. Friedman H, Greenblatt DJ. Rational therapeutic drug monitoring. *JAMA*; 256:2227-2238, 1986.
2. Sawyer WT. The digitalis glycosides. In: Taylor WJ, Caviness MD. A textbook for the clinical application of therapeutic drug monitoring. First edition. Irving, TX: Abbott Laboratories, 83-96, 1988.
3. Matzuk MM, Shlomchik M, Shaw LM. Making digoxin therapeutic drug monitoring more effective. *Therapeutic Drug Monitoring*; 13:215-19, 1991.
4. Klein-Schwartz W, Oderda GM. Poisoning in the elderly: epidemiological, clinical and management considerations. *Drugs and Aging*; 1:67-89, 1991.
5. What are pharmacists dispensing most often? *Pharmacy Times*, 47-66, 1992.
6. Selzer A. Role of serum digoxin assay in patient management. *J Am Coll Card*; 5:106-10, 1985.
7. Marcus FL. Use and toxicity of digitalis. *Heart Dis Stroke*; 1:27-31, 1992.
8. Smith TW. Pharmacokinetics, bioavailability, and serum levels of glycosides. *J Am Coll Card*; 5:43-50, 1986.
9. Correlation coefficient versus prediction error in assessing the accuracy of digoxin dosing methods. *Clin Pharm*; 3:178-83, 1984.
10. Aronson JK. Indications for the measurement of plasma digoxin concentrations. *Drugs*; 26:230-42, 1983.
11. Whiting B, Kelman AW, Bryson SM, et al. Clinical pharmacokinetics: a comprehensive system for therapeutic drug monitoring and prescribing. *Br Med J*; 288:541-5, 1984.
12. Alvisi F, Uberti E, Longhini C, et al. Evidence for circadian rhythm of digoxin bioavailability. *Chronopharm and Chronotherap*, 1981.
13. Dobbs RJ, O'Neill JJA, Deshmukh AA, et al. Serum concentration monitoring of cardiac glycosides. *Clin Pharmacokinet*; 20(3):175-93, 1991.
14. Rajda MJ, Belock S. Drug reduction works. *Institutes Nurs Home*; 28-44, 1985.

Editorials

The following editorial on domestic violence underscores an important subject in South Carolina, and the Board of Trustees of the SCMA has recommended that we take special note that October is domestic violence month. We hope to have more on the subject at a later date.

Guest editorials express the opinions of the authors and do not necessarily reflect the policy of the Editorial Board or the SCMA Board of Trustees.

—CSB

DOMESTIC VIOLENCE: A PERINATAL AND PEDIATRIC RISK FACTOR

Looking back, it barely seems possible that when the events in Union, SC first hit the headlines, many did not even realize that the culprit involved in the disappearance of the two children was no one else but their own mother. For good reason. Our knowledge of human behavior was largely limited to the fact that such heinous crime could not be perpetrated by one of the parents. Now the trauma of the outcome is indelibly burnt into the heart and psyches of many citizens in the state, the nation, if not the world; many individuals felt bilious, nauseous after learning that the mother allegedly did indeed murder her two toddlers. Furthermore, the horrifying accounts written about the tragic aftermath are emetic in content and are not to be recommended for prime-time, breakfast reading!

Although, in many respects, children in the United States have never been physically healthier than they are today, a significant number of those children are at risk of abuse and death. Among those risk factors are poverty, divorce, single-parent households, school failure, teenage pregnancy, drug and alcohol abuse, suicide, injuries, and problems related to learning and behavior. But it is infanticide or murdering children that represents the darkest face of human behavior. Unfortunately, the reasons behind such monstrous crime are poorly understood and rarely prevented. Certainly,

crying and anger without rationally discussing and comprehending the causes of such tragedy can seldom solve the problem. To begin with, a cursory look at the statistics may shed a light on the magnitude of the current social challenges. With the number of divorces in 1993 exceeding the number of marriages, single-parent families are becoming the norm. At the present time, one in four children is illegitimate. Children in female-headed households have a poverty rate of 55 percent, five times the rate in two-parent families.

Violence is a major cause of death among adolescents and young adults. From 1985 to 1991, the annual crude homicide rate for the United States increased 25 percent (from 8.4 to 10.5 per 100,000 persons), and for 20-24-year-old males, the rate increased 76 percent (from 23.4 to 41.2). Overall, homicide has risen over the past several decades to become the second leading cause of death for all 15 to 24 years olds. The United States has one of the highest homicide rates in the industrialized world, 10 times higher than that of England and 25 times higher than that of Spain. Of particular concern to the perinatal health care providers is the dramatic rise in the number of physically abused women in the United States. Transcending educational, religious, economic, ethnic, and age barriers, domestic violence is emerging as a major risk to women. For unknown reasons,

pregnancy is considered to be a time of increased risk for domestic abuse, with more abdominal blows than facial blows reported. In addition to the physical and psychological harm to pregnant women, domestic violence may cause fetal death, preterm labor, and delivery. Moreover, more than half of the men who abuse their female partners also abuse or threaten their children.

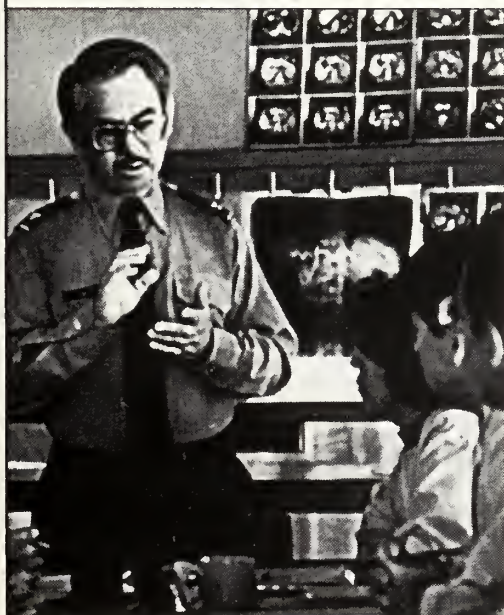
There are no magic solutions, but admitting that there is a problem is a step in the direction of finding one. In addition, the magnitude and characteristics of the problem cry out for new,

creative approaches providing some insight into the direction that needs to be taken. Perinatal health care providers, pediatricians and other physicians cannot ignore this important public health and safety issue and can in fact make a contribution to its resolution through prevention, treatment, and research.

References are available upon request.

Sami B. Elhassani, M. D.
100 Willow Lane
Spartanburg, SC 29307-1343

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Letters to the Editor

To the Editor:

I appreciated receiving the article, "Comprehensive Care of the Cleft Lip and Palate Patient," by Drs. Davis and Giles in the October 1994 edition of *The Journal of the South Carolina Medical Association*. I was a little dismayed that they did not choose to consider eye disease and vision problems in the comprehensive management of such patients. The Craniofacial Anomalies Clinic in Columbia has had Ophthalmology participation in the team evaluation of such patients since 1989. In a series of 172 consecutive patients evaluated from 1989 to 1992, 44 percent, or 75 of 172 patients, were found to have definitive evidence of eye disease. The problems encountered ranged from very simple refractive errors, which were uncorrected, to more serious problems including eyelid abnormalities, tearing problems, misalignments of the eyes or strabismus, amblyopia and cataracts.

I hope that all physicians treating children with craniofacial abnormalities realize that eye and vision evaluation is an essential part of evaluation of these children and secondly that such early treatment may have a marked impact on the educational outcome of such children.

Thank you again for your attention to this subject, which is near and dear to my heart.

Linda M. Christmann, M. D.

9 Richland Medical Park, Suite 340
Columbia, SC 29203

Dr. Christmann's letter was referred to the authors, who responded as follows:

To the Editor:

We appreciate Dr. Christmann's informative letter regarding our article, "Comprehensive Care of the Cleft Lip and Palate Patient," which was published in the October issue of *The Journal of the South Carolina Medical Association*. We did not intend to minimize ophthalmological care of the child with a facial malfor-

mation when we omitted ophthalmology in our brief review article.

The American Cleft Palate and Craniofacial Association* states that approximately one-half of the infants with cleft lip or palate have an associated malformation which may be minor or major. In the Association's official parameters for the longitudinal evaluation and treatment of pediatric patients with cleft lip/palate or other craniofacial anomalies, ophthalmologic evaluation is not mentioned as a standard. However, a number of specialties not cited in our review are often asked to participate in the care of these patients. These include anesthesiology, neurosurgery, gastroenterology, ophthalmology, physical anthropology, neurology, and radiology.

We appreciate Dr. Christmann's calling to our attention her unpublished data regarding eye disease in children with cleft lip and palate. Certainly both proper vision and hearing are necessary to maximize the developmental potential of a child.

The Craniofacial Clinic of Columbia, South Carolina, is fortunate to have such active participation by Dr. Christmann. This type of multidisciplinary commitment to children with special needs provides the best care for these patients.

Paul T. Davis, M. D.

William C. Giles, M. D.

9 Richland Medical Park, Suite 510
Columbia, SC 29203

*Reference: Parameters for the Evaluation and Treatment of Patients with Cleft Lip-Palate or Other Craniofacial Anomalies. American Cleft Palate-Craniofacial Association. *Cleft Palate-Craniofacial Journal*, 1993; 30 (Supplement 1).

To the Editor:

In reviewing the introduction by Drs. Hochman and Osguthorpe of the recent review issue on otolaryngology, note is made of a commendable mention of multidisciplinary
(continued on page 121)



Continuing Medical Education

Second Quarter
1995
Calendar

James L. Haynes, M. D., Chairman

Published by the SCMA Committee on Continuing Medical Education
Post Office Box 11188, Columbia, SC 29211

Note: CME activities in neighboring states are listed when space permits.

MARCH

Tuesday March 28, 1995
Columbia, SC, Adam's Mark Hotel
Children's Health Care Reform: The Challenge, The Need
SPONSOR: USC School of Medicine
DESCRIPTION: Focus on children's health issues emphasizing access, prevention and health reform activities.
TYPE OF AUDIENCE: Pediatricians and family practitioners
CONTACT: Susan Pearson (803) 434-4211 or Betsy Volf, (803) 343-5510
PROGRAM FEE: \$15 and \$25
CULTY: Various regional speakers
CME CREDITS: 2 Hours, AMA Category 1

Monday-Saturday March 31-April 1, 1995
Columbia, SC, Embassy Suites Hotel
14th Annual Carolina Cup Pediatric Symposium
SPONSOR: USC School of Medicine
DESCRIPTION: Annual symposium to provide attendees with recent clinical advances in care of pediatric patients.
TYPE OF AUDIENCE: Pediatricians and family practitioners
CONTACT: Susan Pearson (803) 434-4211 or Linda Lowe, (803) 376-4030
PROGRAM FEE: \$135
CULTY: Guest Faculty and USCSM faculty
CME CREDITS: 8 Hours, AMA Category 1

APRIL

Monday-Friday April 3-7, 1995
Columbia, SC, Richland Memorial Hospital
Primary Training in Hyperbaric Medicine
SPONSOR: USC School of Medicine
DESCRIPTION: Comprehensive introduction to the role of hyperbaric oxygen therapy in modern medical practice.
TYPE OF AUDIENCE: Physicians, nurses, and hyperbaric technicians
CONTACT: Dick Clarke (803) 434-7101
PROGRAM FEE: \$650
CULTY: USCSM faculty
CME CREDITS: 40 Hours, AMA Category 1 ; 40 Hours

AAFP Prescribed Hours; 40 Hours American College of Emergency Physicians

Wednesday April 5, 1995
Columbia, SC, James F. Byrnes Center for Geriatric Medicine, Education and Research
Research Conference
SPONSOR: USC School of Medicine, Div. of Geriatrics
DESCRIPTION: Methodology and current research in geriatrics.
TYPE OF AUDIENCE: Multidisciplinary
CONTACT: JoAnn Watts (803) 734-0812
FACULTY: Carlton A. Hornung, PhD, MPH
CME CREDITS: 1 Hour, AMA Category 1

Wednesday April 12, 1995
Columbia, SC, James F. Byrnes Center for Geriatric Medicine, Education and Research
Grand Rounds
SPONSOR: USC School of Medicine, Div. of Geriatrics
DESCRIPTION: Nutrition in the elderly.
TYPE OF AUDIENCE: Multidisciplinary
CONTACT: JoAnn Watts (803) 734-0812
FACULTY: Cass Ryan, PhD, RD
CME CREDITS: 1 Hour, AMA Category 1

Thursday-Sunday April 20-23, 1995
Charleston, SC, Omni Hotel
The 147th Annual SCMA Scientific Assembly
SPONSOR: The SCMA, MUSC and the SCAAFP
CONTACT: Debbie Shealy (803) 798-6207, ext. 223
CME CREDITS: 14 Hours, AMA Category 1 and 14 AAFP Prescribed Hours

Thursday-Sunday April 20-23, 1995
Charleston, SC, Mills House Hotel
Postgraduate Course in Surgery
SPONSOR: MUSC
DESCRIPTION: This course will provide an update for practicing surgeons on current topics, concepts, issues and problems relative to the broad field of general surgery.
TYPE OF AUDIENCE: Practicing surgeons
CONTACT: Anne Tokarczyk (803) 792-9393
PROGRAM FEE: \$450 before March 20; \$525 after

March 20

FACULTY: Guest faculty and MUSC faculty

CME CREDITS: 21.25 Hours, AMA Category 1

Wednesday

April 26, 1995

Columbia, SC, James F. Byrnes Center for Geriatric
Medicine, Education and Research

Journal Club

SPONSOR: USC School of Medicine, Div. of Geriatrics

DESCRIPTION: Discussion of multidisciplinary topics
with geriatric emphasis

TYPE OF AUDIENCE: Multidisciplinary

CONTACT: JoAnn Watts (803) 734-0812

FACULTY: Victor A. Hirth, MD

CME CREDITS: 1 Hour, AMA Category 1

Wednesday-Sunday

April 26-29, 1995

Hilton Head Island, SC, Sea Pines Resort

Pediatrics Update

SPONSOR: SC Academy of Family Physicians

CONTACT: George M. Converse, MD (205) 783-5276

CME CREDITS: 14.25 AAFP Prescribed Hours

Thursday

April 27, 1995

Columbia, SC, Hall Psychiatric Institute

Psychotropic Drugs in the Special Need Population

SPONSOR: USC School of Medicine

DESCRIPTION: The use of psychotropic drugs in
the treatment of emotional and behavioral disorders.

TYPE OF AUDIENCE: Physicians, psychologists, social
workers and nurses

CONTACT: Susan Pearson (803) 434-4211

FACULTY: Guest faculty

CME CREDITS: 5 Hours, AMA Category 1

Thursday-Friday

April 27-28, 1995

Charleston, SC, MUSC

Advanced ERCP

SPONSOR: MUSC

DESCRIPTION: Will expose participants to new tech-
niques in ERCP, leading to a better understanding of the indi-
cations, benefits and risks.

TYPE OF AUDIENCE: Practicing gastroenterologists/
surgeons already performing advanced techniques.

CONTACT: Rita Oden (803) 792-4165

PROGRAM FEE: \$950

FACULTY: Guest faculty and MUSC faculty

CME CREDITS: 14.5 Hours, AMA Category 1

Friday-Saturday

April 28-29, 1995

Columbia, SC, Williams Brice Stadium

Primary Care Issues in Sports Medicine

SPONSOR: USC School of Medicine

DESCRIPTION: Update primary care physicians on cur-
rent issues in sports medicine.

TYPE OF AUDIENCE: Family practitioners, internists,
pediatricians, emergency medicine and athletic trainers

CONTACT: Susan Pearson, (803) 434-4211

PROGRAM FEE: Physicians \$200; Athletic Trainers, P.T.

FACULTY: Guest faculty and USCSM faculty

CME CREDITS: 9 Hours, AMA Category 1 ; 9 AAFP Pre-
scribed Hours; 9 CEU Board of Certified National Athle-
Trainer's Association

MAY

Wednesday

May 3, 1995

Columbia, SC, James F. Byrnes Center for Geriatric
Medicine, Education and Research

Research Conference

SPONSOR: USC School of Medicine, Div. of Geriatrics

DESCRIPTION: Methodology and current research in
geriatrics.

TYPE OF AUDIENCE: Multidisciplinary

CONTACT: JoAnn Watts (803) 734-0812

FACULTY: Carlton A. Hornung, PhD, MPH

CME CREDITS: 1 Hour, AMA Category 1

Wednesday

May 10, 1995

Columbia, SC, James F. Byrnes Center for Geriatric
Medicine, Education and Research

Grand Rounds

SPONSOR: USC School of Medicine, Div. of Geriatrics

DESCRIPTION: Pain management.

TYPE OF AUDIENCE: Multidisciplinary

CONTACT: JoAnn Watts (803) 734-0812

FACULTY: Dixie Hines, MD, RMH

CME CREDITS: 1 Hour, AMA Category 1

Wednesday

May 24, 1995

Columbia, SC, James F. Byrnes Center for Geriatric
Medicine, Education and Research

Journal Club

SPONSOR: USC School of Medicine, Div. of Geriatrics

DESCRIPTION: Cancer in the elderly.

TYPE OF AUDIENCE: Multidisciplinary

CONTACT: JoAnn Watts (803) 734-0812

FACULTY: N. David List, MD

CME CREDITS: 1 Hour, AMA Category 1

Friday-Sunday

May 26-28, 1995

Hilton Head Island, SC, Hyatt Regency

Pediatrics Advances

SPONSOR: SC Academy of Family Physicians

CONTACT: Ann Vileikis (708) 228-5005, ext. 7657

CME CREDITS: 15 AAFP Prescribed Hours

Friday-Monday **May 26-29, 1995**
Charleston, SC, Hawthorn Suites Hotel
Spoletto Symposium - Advanced Vocal Arts Medicine
SPONSOR: MUSC
DESCRIPTION: This advanced course is designed for the otolaryngologists, speech pathologists and vocal professionals who wish to further their understanding of vocal mechanisms and voice disorders.
TYPE OF AUDIENCE: Practicing otolaryngologists
CONTACT: Lucinda Halstead, MD (803) 792-7162
PROGRAM FEE: \$400
FACULTY: Guest faculty and MUSC faculty
CME CREDITS: 19 Hours, AMA Category 1

Wednesday-Saturday **May 31-June 3, 1995**
Charleston, SC, Omni Hotel
Cardiology Update for the Primary Care Physician
SPONSOR: American College of Cardiology
DESCRIPTION: The intent of this program is to bring the most recent advances in cardiovascular disease to the primary care physician.
TYPE OF AUDIENCE: Primary care physicians
CONTACT: Odessa Ussery, (803) 792-4071
PROGRAM FEE: \$410 for ACC members; \$495 for non-members
FACULTY: Guest faculty and MUSC faculty
CME CREDITS: 18.5 Hours, AMA Category 1 and 18.5 AAFP Prescribed Hours

JUNE

Thursday-Saturday **June 1-3, 1995**
Charleston, SC, Hawthorn Hotel
Family Medicine Update: New Drug Update
SPONSOR: Department of Family Medicine - MUSC
DESCRIPTION: This course is designed to update primary care physicians on new drugs.
TYPE OF AUDIENCE: Primary care physicians
CONTACT: Geri LaVia, (803) 792-2426
PROGRAM FEE: TBA
FACULTY: Guest faculty and MUSC faculty
CME CREDITS: 20 AAFP Prescribed Hours

Thursday-Sunday **June 1-4, 1995**
Charleston, SC, Mills House Hotel
1995 Cataract and Refractive Surgery Update
SPONSOR: Department of Ophthalmology - MUSC
DESCRIPTION: This course is a comprehensive identifying advanced technical and current concepts related to cataracts and refractive surgery. Roundtable sessions, interactive group discussions and wet labs will be included in the course design.
TYPE OF AUDIENCE: Practicing ophthalmologists
CONTACT: Maddie Manuel, (803) 792-2760
PROGRAM FEE: \$300 pre-registration; \$350 on-site registration
FACULTY: Guest faculty and MUSC faculty
CME CREDITS: 16 Hours, AMA Category 1

Friday-Sunday **June 2-4, 1995**
Charleston, SC, Psychiatric Institute Auditorium, MUSC

8th Annual Update in Psychiatry
SPONSOR: Department of Psychiatry - MUSC
DESCRIPTION: This course is designed to educate psychiatrists and neurologists in the latest advances in their fields.
TYPE OF AUDIENCE: Practicing psychiatrists and neurologists
CONTACT: Pam McKinney, (803) 852-4211
PROGRAM FEE: TBA
FACULTY: Guest faculty and MUSC faculty
CME CREDITS: TBA

Monday-Friday **June 5-9, 1995**
Columbia, SC, Richland Memorial Hospital
Primary Training in Hyperbaric Medicine
SPONSOR: USC School of Medicine
DESCRIPTION: Comprehensive introduction to the role of hyperbaric oxygen therapy in modern medical practice.
TYPE OF AUDIENCE: Physicians, nurses, and hyperbaric technicians
CONTACT: Dick Clarke (803) 434-7101
PROGRAM FEE: \$650
FACULTY: USCSM faculty
CME CREDITS: 40 Hours, AMA Category 1 ; 40 AAFP Prescribed Hours; 40 Hours American College of Emergency Physicians

Wednesday **June 6, 1995**
Columbia, SC, James F. Byrnes Center for Geriatric Medicine, Education and Research
Research Conference
SPONSOR: USC School of Medicine, Div. of Geriatrics
DESCRIPTION: Methodology and current research in geriatrics.
TYPE OF AUDIENCE: Multidisciplinary
CONTACT: JoAnn Watts (803) 734-0812
FACULTY: Carlton A. Hornung, PhD, MPH
CME CREDITS: 1 Hour, AMA Category 1

Wednesday-Saturday **June 6-10, 1995**
Hilton Head Island, SC, Westin Resort
4th Annual Advanced Coronary Interventions
SPONSOR: UNC School of Medicine
CONTACT: Mary A. Cox (800) 874-2417 or (704) 355-3120
PROGRAM FEE: \$650
CME CREDITS: 18 Hours, AMA Category 1

Wednesday-Friday **June 7-9, 1995**
Charleston, SC, Omni Hotel
Reconstruction of the Arthritic Hip and Knee
SPONSOR: Department of Orthopaedic Surgery - MUSC
DESCRIPTION: This course is designed to update the practicing orthopaedic surgeon on the clinical, economic and ethical issues affecting reconstruction of the arthritic hip and knee.
TYPE OF AUDIENCE: Practicing orthopaedic surgeons
CONTACT: Odessa Ussery, (803) 792-4071
PROGRAM FEE: \$395 before April 28; \$495 after April 28
FACULTY: Guest faculty and MUSC faculty
CME CREDITS: 16 Hours, AMA Category 1

Wednesday **June 14, 1995**
**Columbia, SC, James F. Byrnes Center for Geriatric
Medicine, Education and Research**

Grand Rounds

SPONSOR: USC School of Medicine, Div. of Geriatrics
DESCRIPTION: Depression in the elderly.
TYPE OF AUDIENCE: Multidisciplinary
CONTACT: JoAnn Watts (803) 734-0812
FACULTY: Lynn Hackett, MD
CME CREDITS: 1 Hour, AMA Category 1
CME CREDITS: 41.25 AAFP Prescribed Hours

Monday-Saturday **June 12-17 1995**

Isle of Palms, SC, Wild Dunes Resort

Intensive Review of Family Medicine

SPONSOR: Department of Family Medicine - MUSC
DESCRIPTION: This course is designed to review problems in family medicine and practical approaches to prevention, education and treatment.
TYPE OF AUDIENCE: Primary care physicians
CONTACT: Geri LaVia, (803) 792-2426
PROGRAM FEE: \$475
FACULTY: Guest faculty and MUSC faculty

Wednesday-Saturday **June 14-17, 1995**

Hilton Head Island, SC, Sea Pines Resort

Adult Infectious Disease Seminar

SPONSOR: SC Academy of Family Physicians
CONTACT: George M. Converse, MD (205) 783-5276
CME CREDITS: 17.25 AAFP Prescribed Hours

Wednesday-Monday **June 14-19, 1995**

Kiawah Island, SC, Kiawah Island Resort

Radiology 2000

SPONSOR: Department of Radiology- MUSC
DESCRIPTION: This course is designed to update the practicing radiologist on current topics, concepts and issues relative to the broad field of Diagnostic Radiology.
TYPE OF AUDIENCE: Practicing radiologists
CONTACT: Clydie De Brux, (803) 792-4267
PROGRAM FEE: TBA
FACULTY: Guest faculty and MUSC faculty
CME CREDITS: 16 Hours, AMA Category 1

Sunday-Friday **June 18-23, 1995**

Hilton Head Island, SC, Hilton Head Resort

Pediatric Emergency Medicine

SPONSOR: SC Academy of Family Physicians
CONTACT: Olga Korytko, MD (215) 590-4519
CME CREDITS: 26.75 AAFP Prescribed Hours

Wednesday-Saturday **June 21-24, 1995**

Hilton Head Island, SC, Sea Pines Resort

Pediatric Infectious Disease Seminar

SPONSOR: SC Academy of Family Physicians
CONTACT: George M. Converse, MD (205) 783-5276
CME CREDITS: 17.25 AAFP Prescribed Hours

Friday-Saturday **June 23-24, 1995**

Greenwood, SC

Annual Festival of Flowers Medical Symposium

SPONSOR: Self Memorial Hospital
DESCRIPTION: Update in medical topics of interest to generalist physicians.
TYPE OF AUDIENCE: Primary care physicians
CONTACT: Stoney Abercrombie, MD (803) 227-4869
PROGRAM FEE: \$25
FACULTY: Various national and regional speakers
CME CREDITS: 9 Hours, AMA Category 1 and 9 AAFP Prescribed Hours

Tuesday-Saturday **June 27-July 1, 1995**

Hilton Head Island, SC, Sea Pines Resort

Family Practice Seminar

SPONSOR: SC Academy of Family Physicians
CONTACT: George M. Converse, MD (205) 783-5276
CME CREDITS: 17.25 AAFP Prescribed Hours

Wednesday **June 28, 1995**

**Columbia, SC, James F. Byrnes Center for Geriatric
Medicine, Education and Research**

Journal Club

SPONSOR: USC School of Medicine, Div. of Geriatrics
DESCRIPTION: Discussion of multidisciplinary topics with geriatric emphasis.
TYPE OF AUDIENCE: Multidisciplinary
CONTACT: JoAnn Watts (803) 734-0812
FACULTY: Lisa Wilson, MD
CME CREDITS: 1 Hour, AMA Category 1

approaches to difficult clinical problems and collaboration in the management of problems such as cleft lip and palate.

The discussion of physicians involved in the care of the patients has a glaring deficiency – the Plastic and Reconstructive Surgeon.

Sutton L. Graham II, M. D.
135 Commonwealth Drive, Suite 360
Greenville, SC 29615

Dr. Graham's letter was referred to the guest editors, who responded as follows:

To the Editor:

The Introduction section of the recent *Journal* issue on "Update on Otolaryngology Head and Neck Surgery" presented, per routine, "thumbnail" sketches of the articles. The multidisciplinary approach outlined by Drs. Davis and Giles refers to their very active cleft lip/palate teams which include a "speech

pathologist, dental specialist, cleft surgeon, social worker, psychologist and geneticist." Both Dr. Davis and Dr. Giles are otolaryngologists who subspecialize in facial plastic and reconstructive surgery, and they handle the cleft repair, secondary ear disease and potential airway compromise in their patients. In other teams within South Carolina, general plastic and reconstructive surgeons handle the cleft lip/palate repairs, and general or pediatric otolaryngologists the secondary ear and potential airway problems. Whatever, the article by Giles and Davis appropriately reflects the experience of their teams.

J. David Osguthorpe, M. D.
Department of Otolaryngology and
Communicative Sciences
Medical University of South Carolina
171 Ashley Avenue
Charleston, SC 29425-2242

PHYSICIAN RECOGNITION AWARDS

The following SCMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned.

Luke D. Baxley, M. D.
U. Hoyt Bodie, M. D.
Mary J. Cagle, M. D.
Jose De Jesus Chavez, M. D.
Dawn H. Clancy, M. D.
John R. Cook, M. D.
Harvey F. Hatcher, M. D.
Michael M. Hawkins, M. D.
Stephen R. Intemann, M. D.
Tahir A. Javed, M. D.
E. Neal Powell, M. D.
J. Smythe Rich, M. D.
Hudson C. Rogers, M. D.
Peter A. Tucci, M. D.
William T. Weathers, M. D.

On the Cover:

CHARLES RAYSOR MAY, M. D., 1872-1947 PRESIDENT, SCMA: 1930

Charles Raysor May was born in Yorkville, SC, June 30, 1872. He attended the Medical College of Virginia and was a 1897 graduate of the Medical College of the State of South Carolina. As such, he became one link in an impressive family medical history chain. His father, John May, was a 1843 graduate of the MCSSC, and his two sons, Charlie and John, graduated in 1942 and 1947 respectively. Dr. May's daughter, Louise May Foster, is a registered nurse; a grandson, a 1962 MUSC graduate; granddaughter, a speech pathologist; and great grandchildren are a dentist, a nurse, and a medical student.

After graduating from medical college, Dr. May practiced in Blenheim, SC until 1904 when he settled permanently in Bennettsville where he continued in general practice until his death in 1947.

While in Blenheim, concerned that the drinking water from the shallow wells might be a source of disease-causing bacteria, Dr. May encouraged his patients to drink the Blenheim mineral springs water which he had found to be pure. To make the taste more appealing, he added ginger and sugar and soon began bot-

tlung the mix. Thus was born Blenheim Ginger Ale. It is said that the current owners still use Dr. May's recipe.

Dr. May did postgraduate work in surgery in New York and special attention was given to this specialty in his practice. He was active in many medical and civic organizations, among them: Marlboro County Medical Society, Pee Dee Medical Association, TriState, Southern, and American Medical Associations. He was a member of the Masons, the Knights Templar, and the Shriners, and was a Deacon of the First Presbyterian Church of Bennettsville.

At his death on January 21, 1947, a resolution of the Marlboro County Medical Society said:

In every sense of the word Dr. May, Sr. was a truly noble Christian gentleman.... He lived his life to the fullest and even on the day of his death he conducted his usual active practice until the call came.

Betty Newsom
The Waring Historical Library

ACKNOWLEDGMENT

Our special thanks to Dr. John May, Bennettsville, who furnished much of the above information on his father.

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Alliance Page

CONVENTION '95 *"A Taste of Charleston"*

The South Carolina Medical Association Alliance will come together in historic Charleston, South Carolina, April 19-20, 1995, for "Convention '95: A Taste of Charleston." The meeting will convene at the Omni Hotel at Charleston Place.

The Executive Board and House of Delegates will meet on Thursday, April 20, 1995. During the brunch on Thursday, county presidents and past state presidents will be honored. At this time a basket of items from across the state will be auctioned. The proceeds will go to AMA-ERF. Diane Chow, AMAA Field Director, will address us at the brunch.

During the registration on Wednesday and Thursday, baskets prepared by the county alliance/auxiliaries will be available for purchase. The proceeds will also go to AMA-ERF.

A pair of Victorian Christmas stockings will be taken home by a lucky draw of tickets. These have been on display throughout the state this year.

We look forward to seeing everyone in Charleston for the SCMAA Convention.

Greenwood County Convention Committee
Margaret Funke, Chairman
Laura VanDerwerker, Co-Chairman
Martha Beaudrot, Co-Chairman
Laurie Cone, Co-Chairman

Classifieds

ORANGEBURG AND CALHOUN COUNTIES have practice opportunities for graduating residents/fellows and experienced practitioners in the following specialties: Emergency Medicine, Family Practice, Orthopedic Sports Medicine and Urology. Practice incentives and relocation assistance are available. *Contact Dr. Chermol, The Regional Medical Center, at (800) 866-6045.*

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OCCUPATIONAL MED OR FAMILY PRACTITIONERS: The USPS is looking for contract physicians in various areas of SC to provide medical management, including pre-placement physicals, assessment of work-related injuries/illnesses, MRO services, fitness-for-duty exams, and consultation with employee's physicians. The contract physician will work closely with USPS management in resolving hiring, fitness-for-duty, injury compensation, labor relations, and medical interpretation problems. Timely, detailed reports which include medical rationale are a must. *Respond with vitae to: USPS/Columbia District; Manager, Human Resources; MDCP, PO Box 929994; Columbia, SC 29292-9994.*

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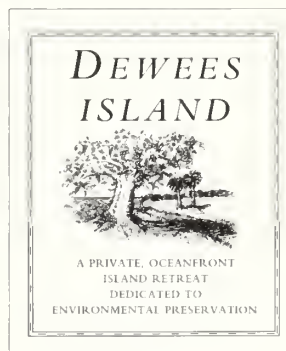
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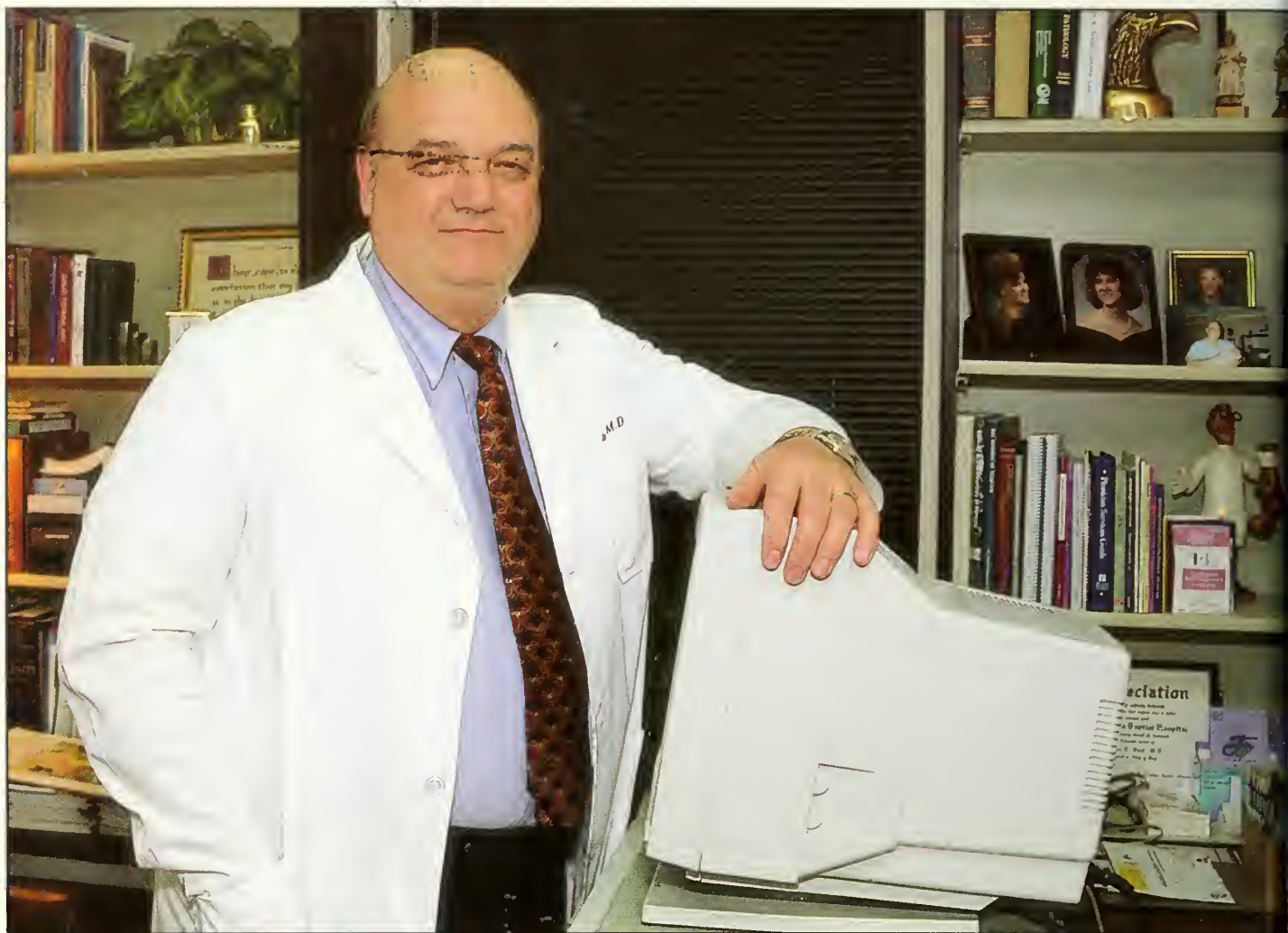
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The Journal



OF THE SOUTH CAROLINA MEDICAL ASSOCIATION

VOLUME 91
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PAGES 157-218

THE 147TH ANNUAL MEETING OF THE SCMA
THE OMNI HOTEL, CHARLESTON, SC
APRIL 20 - APRIL 23, 1995

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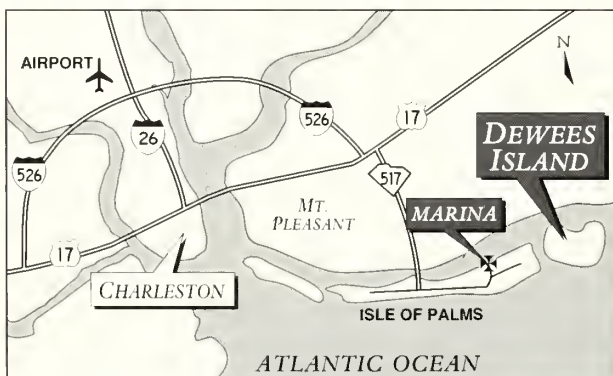
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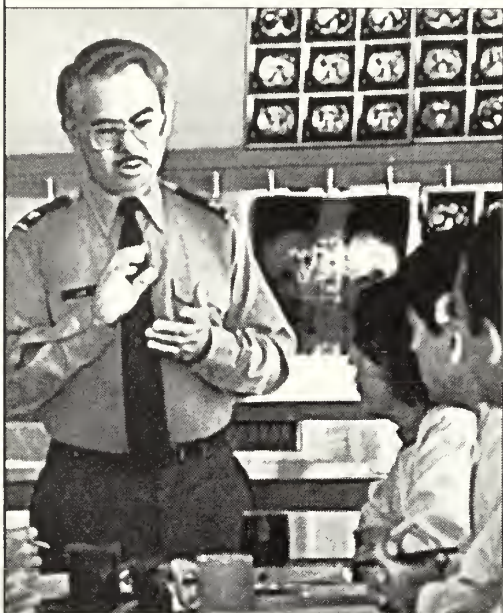


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President's Page

PUTTING LIPSTICK ON THE PIG

Tommy Hendrick, the famous outfielder, once commented that "Catching the ball is a pleasure, but knowing what to do with it is a business." In these President's pages, I have attempted to expose (catch) issues affecting our destiny. In this last page, I am proud to report that our South Carolina Medical Association (SCMA) staff and leadership have developed and are actively implementing programs (business plans) that will assure the well-being of our profession. I am not speaking of IPAs, PPOs, HMOs, etc. Likewise, networking, integrating, capitating, and going at risk are not topics for this discussion. These are all "lipsticks" with which we are attempting to position ourselves to the threat or opportunity posed by powerful payors and their managed care companies. The real business is to be staunch and unwavering advocates for our patients and communities.

The Inter-Specialty Council consists of representatives from specialty societies in the SCMA House of Delegates, who focus on health-related bills currently debated in the South Carolina Legislature. During the council's meetings, there has been some consensus, some disagreement, and in every instance a greater awareness and understanding of differing views. More importantly, issues of quality, access to and affordability of health care have permeated the discussions. SCMA members and specialty society physicians can be justly proud that their representatives are putting patient interest high on each agenda item. The potential is enormous for this forum to unify our profession around advocacy for those we serve.

The South Carolina Institute for Medical Education and Research (SCIMER) received a highly competitive Robert Wood Johnson Foundation Reach Out grant to link private practicing physicians with local public health departments in order to provide medical homes for more children in underserved areas. SCIMER's program, PARTNERSHIPS FOR CHILDREN, allows the doctor to care for more patients by utilizing public health providers for support services. This public/private partnership efficiently utilizes local resources while keeping health care where it belongs – in the physician's office. This is truly placing the well-being of the patient and community first.

Finally, there is an exciting new partnership developing between the SCMA and the South Carolina Hospital Association (SCHA). Selected members from both Boards of Trustees, along with appropriate staff, are exploring ways hospitals and physicians can combine energies to better serve patients and communities. With these two dominant health care organizations in any South Carolina locale focusing on access, quality and cost, progress is likely.

In these turbulent times for our beloved profession we must pay attention to the pig (money, profits, market share, etc). Our attempts at organization (PPOs, HMOs, MSOs, etc.) are necessary to deal with the pig. They put a better face on the animal but they do not accomplish what we are really all about – being an effective advocate for our patients and communities. Our destiny lies in this pursuit. Winston Churchill said that the chain of destiny can only be handled one link at a time. I am proud to be a member of the SCMA, an organization that is working hard to build those linkages. Thank you for letting me serve as your 131st President.

O. Marion Burton MD

O. Marion Burton, M. D.
President

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The Journal



OF THE SOUTH CAROLINA MEDICAL ASSOCIATION

VOLUME 91

APRIL 1995

NUMBER 4

THE ONE HUNDRED FORTY-SEVENTH ANNUAL MEETING

THE OMNI HOTEL, CHARLESTON, SOUTH CAROLINA
APRIL 20 - APRIL 23, 1995

The 147th Annual Meeting of the South Carolina Medical Association will mark 15 consecutive years in Charleston and the ninth consecutive year at the Omni Hotel.

Information regarding the meeting, including registration form and hotel reservation form, has been mailed to all South Carolina physicians, but if you have not received this information, call SCMA Headquarters in Columbia (798-6207 or 1-800-327-1021). Again, there is no registration fee for SCMA members, and pre-registration is encouraged.

The House of Delegates meets to consider the business of the association on Friday, April 21, and again on Sunday morning, April 23. Reference Committees will meet on Friday afternoon.

A total of 14 AMA Category 1 and 14 AAFP Prescribed hours have been approved for scientific sessions beginning on Thursday afternoon and continuing through Saturday afternoon. Consult the schedule of events which follows for details on all programs.

Special guests for this annual meeting include Richard F. Corlin, M. D., Vice Speaker of the AMA House of Delegates.

Again this year, the SCMA will serve as the umbrella organization for many specialty societies who will hold business and scientific sessions during the Annual Meeting.

The SCMA Board of Trustees will meet on Thursday, April 22 and at breakfast each day to consider business which arises during the House of Delegates meeting.

This issue of *The Journal* contains reports and resolutions available at publication deadline. Additional reports and resolutions received after this issue has gone to press will be included in the delegates' handbooks which will be mailed prior to the meeting. Delegates are asked to bring their handbooks to the meeting or to pass them along to alternate delegates if they are unable to attend.

— JD

ONE HUNDRED FORTY-SEVENTH ANNUAL MEETING SCHEDULE OF EVENTS

Thursday, April 20, 1995

TIME/LOCATION	EVENT
7:30 a.m.-1:00 p.m. 2nd Floor Lobby	Alliance Registration - Open
8:30 a.m.-10:00 a.m. Colleton Room	Alliance Executive Board Meeting
10:30 a.m.-12:00 p.m. Willow Ballroom	Alliance Presidents' Brunch
11:30 a.m.-7:00 p.m. 2nd Floor Grand Hall	SCMA Registration - Open
12:15 p.m.-1:00 p.m. Louis's Charleston Grill	SCMA Board of Trustees Luncheon
1:00 p.m.-4:00 p.m. Willow Ballroom	Alliance House of Delegates
1:00 p.m.-5:00 p.m. Jenkins/King Room	SCMA Board of Trustees Meeting
1:00 p.m.-5:00 p.m. Magnolia Ballroom	SCMA Plenary Session "What's New in..."
1:00-1:20	Stroke: Timothy D. Carter, MD, MUSC
1:20-1:40	Diabetes: Ronald K. Mayfield, MD, MUSC
1:40-2:00	Seizures: Paul B. Pritchard, III, MD, MUSC
2:00-2:20	Break
2:20-2:40	Laparoscopic Surgery: Frederick L. Greene, MD, USCSM
2:40-3:00	Obstetrics: Fred Shipley, MD, USCSM
3:00-3:20	Newborn Screening: Alva L. Strickland, MD, Spartanburg
3:20-3:40	Break
3:40-4:00	Legal Medicine: Donald Saunders, MD, USCSM Stephen P. Williams, Senior VP and Legal Counsel - SCMA
4:00-4:20	Acute MI: Barry J. Feldman, MD, Columbia
4:20-4:40	Joint Surgery: Richard J. Friedman, MD, MUSC Consultant, Encore Orthopedics
4:40-5:00	ENT: W. David Isenhower, Jr., MD, Greenwood
1:00 p.m.-4:15 p.m. Drayton Room	SC Society of Medical Assistants Scientific Session "Mind Your Business: A Practical Course in Painless Practice Management" -- Elliott Davis and Company Marilyn J. Blessing
3:00 p.m.-7:00 p.m. Dogwood/Cypress/ Live Oak Ballrooms and Grand Hall	Exhibitors Set Up

SCHEDULE OF EVENTS

Friday, April 21, 1995

TIME/LOCATION	EVENT
7:00 a.m.-5:00 p.m. 2nd Floor Grand Hall	SCMA Registration – Open
7:00 a.m.-8:00 a.m. Louis's Charleston Grill	SCMA Board of Trustees Breakfast
7:00 a.m.-8:00 a.m. Beauregard Room	SCMA Past Presidents' Breakfast
7:00 a.m.-8:00 a.m. Edmunds Room	Specialty Society Delegates Meeting
7:00 a.m.-8:00 a.m. Gadsden Room	CME Committee Breakfast Meeting
7:00 a.m.-8:00 a.m. Fenwick Room	Residents Breakfast Meeting (Supported by the AMA Resident Physicians Section)
7:30 a.m.-8:30 a.m. Booths 22 & 65	Coffee/Juice
7:30 a.m.-6:00 p.m. Dogwood/Cypress/ Live Oak Ballrooms and Grand Hall	Exhibits Open
8:00 a.m.-11:30 a.m. Willow/Magnolia Ballrooms	SCMA House of Delegates
9:45 a.m.-10:45 a.m. Booths 22 & 65	Coffee
10:00 a.m.-11:00 a.m. Riley Room	MUSC Medical Alumni Board Meeting
10:00 a.m.-12:00 noon Colleton Room	SC Cardiopulmonary Rehabilitation Association Board of Directors Meeting
11:30 a.m.-12:30 p.m. 2nd Floor Grand Hall	SC Cardiopulmonary Rehabilitation Association Registration
12:00 noon-1:00 p.m. Suite 2K	SC Chapter of the American Academy of Pediatrics Adolescent Section Luncheon Meeting
12:00 noon-1:30 p.m. Louis's Charleston Grill	SCMA Young Physicians' Section Luncheon & Meeting (Supported by the AMA Young Physicians Section)
12:30 p.m.-1:30 p.m. Edmunds Room	Reference Committee Chairmen's Luncheon

— SCHEDULE OF EVENTS —
Friday, April 21, 1995 (continued)

TIME/LOCATION	EVENT
12:45 p.m.-2:15 p.m. Willow Ballroom	MUSC Alumni Luncheon
12:00 noon-5:00 p.m. Jenkins/King Room	<p>SC Dermatological Association Business Meeting and Scientific Session</p> <p>“What’s New in Pediatric Dermatology: Part I” James E. Rasmussen, MD, University of Michigan Medical School, Ann Arbor, MI (Supported by Janssen Pharmaceutica)</p> <p>“Dermatologic Medical Pearls: Part I” Joseph L. Jorizzo, MD, Bowman Gray School of Medicine, Winston-Salem, NC (Supported by Glaxo Dermatology) Grant/Research Support from Ortho, Glaxo, Westwood, Sandoz, Schering, Ortho, Glaxo and Westwood Speaker's Bureaus</p> <p>“What’s New in Dermatologic Therapy” Richard B. Odom, MD, USCF School of Medicine, San Francisco, CA (Supported by the Dermatology Foundation and underwritten by Neutrogena/Leaders Society Lectureship Program)</p> <p>“Complications in Dermatologic Surgery” Neil A. Swanson, MD, Oregon Health Sciences University, Portland, OR (Supported by the Kathleen Riley Lectureship Fund, MUSC)</p>
12:45 p.m.-5:00 p.m. Magnolia Ballroom	<p>SC Cardiopulmonary Rehabilitation Association Symposium</p> <p>“Alternative Conduits in Myocardial Revascularization” Robert A. Frank, MD, The Physicians Center, Marrero, LA</p> <p>“Vascular Rehabilitation” Mitzi Ekers, RN, MS, St. Petersburg, FL</p> <p>“Risk Stratification” William A. Webster, IV, PhD, Heartlife Program, Greenville</p> <p>“Coronary Regression - Using LDL As A Marker—National Cholesterol Association Education Program” Christie B. Hopkins, MD, Columbia</p>
1:00 p.m.-3:00 p.m. Beauregard Room	<p>SCMA Workshop: “Changes in Health Care” “The Physicians Response” Henry S. Jordan, MD, Anderson</p> <p>“The Institutional/Provider Response” Bill Prince, SC Hospital Association</p>

— SCHEDULE OF EVENTS —
Friday, April 21, 1995 (continued)

TIME/LOCATION	EVENT
	<p>“The Payors Response” Francis G. Middleton, MD, Charleston President, Healthsource South, Inc.</p> <p>“Tieing it all Together” Sam Baker, PhD, USC</p> <p>Panel Discussion: Speakers listed above and Ben Mitchell, PhD, University of Tennessee, and Stephen P. Williams, JD, SC Medical Association</p>
1:00 p.m.-2:00 p.m. Suite 2J	<p>Joint Session: SC College of Emergency Physicians and SC Psychiatric Association</p> <p>“Domestic Violence: The Role of the Physician” Peter L. Owens, MD, Greenville Gail Bundow, MD, Greenville</p>
1:30 p.m.-3:00 p.m. Hampton, Fenwick and Gadsden Rooms, Suite 2G	<p>SCMA Reference Committee Meetings (Specific room assignments will appear in Delegates Handbook)</p>
2:00 p.m.-3:00 p.m. Suite 2J	<p>SC College of Emergency Room Physicians Scientific Session and Business Meeting</p> <p>“The World Trade Center Disaster” Edward J. Gabriel, BA, MPA, AEMT-P Deputy Chief, Commanding Officer, NYC*EMS Station #23</p>
2:00 p.m.-3:00 p.m. Suite 2H	<p>SC Psychiatric Association Scientific Session</p> <p>“The Relationship Between Psychiatry and Primary Care” James C. Ballenger, MD, MUSC</p>
2:00 p.m.-4:00 p.m. Suite 2L	<p>SC Orthopaedic Association Business Meeting</p>

— SCHEDULE OF EVENTS —
Friday, April 21, 1995 (continued)

TIME/LOCATION	EVENT
2:00 p.m.-4:30 p.m. Colleton Room	<p>SC Chapter of the American Academy of Pediatrics/CRS Combined Scientific Session</p> <p>“Children’s Rehabilitative Services Update” Ronald C. Porter, MD, Columbia</p> <p>“A Multidisciplinary Approach to the Care of Children with Craniofacial Anomalies” The Craniofacial Clinic, USCSM, Division of Plastic Surgery Rami Kalus, MD, USCSM Harold I. Friedman, MD, PhD, USCSM Thomas G. Liszka, MD, USCSM Gale Coston, EdD, USC Michael Cuccaro, PhD, USCSM</p>
2:15 p.m.-3:15 p.m. Booths 22 & 65	Coffee Break
2:30 p.m.-4:00 p.m. Edmunds Room	<p>SC Society of Plastic & Reconstructive Surgeons Scientific Session</p> <p>“Physiology of Wound Healing - Basic Wound Repair” Samuel S. Matthews, Jr., MD, Greenville</p> <p>“Management of Difficult Wounds” Steven K. White, Sr., MD, Myrtle Beach</p> <p>“Innovations in Cleft Lip and Palate for the Primary Care Physician” Richard C. Hagerty, MD, Charleston</p>
3:00 p.m.-5:00 p.m. Drayton Room	<p>SCMA Workshop: “Recognition and Prevention of Adolescent Alcohol and Drug Use:” Presented by The Fighting Back of the Midlands Physicians Committee Benjamin O. Stands, MD, Columbia N. Peter Johnson, PhD, USC</p>
3:00 p.m.-5:00 p.m. Hampton, Fenwick and Gadsden Rooms	<p>SCMA Reference Committee Meetings (Specific room assignments will appear in Delegates Handbook)</p>
4:00 p.m.-6:00 p.m. Dogwood/Cypress/ Live Oak Ballrooms and Grand Hall	<p>SCMA Reception Honoring Delegates, Alternates, Speakers and Exhibitors (All Registrants Welcome)</p>

SCHEDULE OF EVENTS
Friday, April 21, 1995 (continued)

TIME/LOCATION	EVENT
5:00 p.m.-6:30 p.m. SCCRA President's Suite	SC Cardiopulmonary Rehabilitation Association Reception
5:00 p.m.-7:00 p.m. Beauregard Room	USC School of Medicine Alumni and Faculty Reception
5:30 p.m.-7:30 p.m. Suite 2G	SC Chapter of the American Academy of Pediatrics Cocktail Reception
6:00 p.m. Lodge Alley Inn	MUSC Reunion: Class of 1980 Reception
6:30 p.m.-9:30 p.m. Old Exchange Building	SC Society of Anesthesiology Reception and Dinner
7:00 p.m. Bennett House	MUSC Class of 1965 Reception
7:00 p.m. The Cavallaro Restaurant	MUSC Reunion: Class of 1950
7:00 p.m. Jenkins/King Room	MUSC Reunion: December Class of 1943
7:00 p.m.-8:00 p.m. Colleton Room	SC Radiological Society Cocktail Reception
7:30 p.m. Magnolia Ballroom Willow Ballroom	MUSC Reunions: Class of 1975 Class of 1985
7:30 p.m.-9:00 p.m. The Harbour Club	SC Dermatological Association Reception

Saturday, April 22, 1995

7:00 a.m.-5:00 p.m. 2nd Floor Grand Hall	SCMA Registration Open
7:00 a.m.-8:15 a.m. 2nd Floor Terrace (Backup Suite 2L)	SC Society of Anesthesiologists Breakfast Meeting
7:15 a.m.-8:30 a.m. Edmunds Room	Editorial Board Breakfast
7:15 a.m.-8:30 a.m. Suite 2J	SC Radiological Society Breakfast Meeting Guest Speaker: "America and Radiation – A Roller Coaster Love Affair" David J. DiSantis, MD, Eastern VA Medical School, Norfolk, VA

— SCHEDULE OF EVENTS —
Saturday, April 22, 1995 (continued)

TIME/LOCATION	EVENT
7:30 a.m.-8:30 a.m. Louis's Charleston Grill	SCMA Board of Trustees Breakfast
7:30 a.m.-9:00 a.m. Suite 2K	SC Chapter of the American Academy of Pediatrics Executive Committee Meeting
7:45 a.m.-8:45 a.m. Booths 22 & 65	Coffee/Juice
7:30 a.m.-8:00 a.m. Gadsden Room	SC Vascular Surgery Society Continental Breakfast
8:00 a.m.-10:00 a.m. Suite 2G	Business Meeting and Continental Breakfast of the SC Society of Pathologists
8:00 a.m.-1:00 p.m. Dogwood/Cypress/ Live Oak Ballrooms and Grand Hall	Exhibits Open
8:00 a.m.-12:00 noon Hampton Room	SC Vascular Surgery Society Scientific Session and Business Meeting "Carotid Endarterectomy With Homologous Vein Patch Graft Angioplasty: Review of 1,006 Cases" James F. Howell, MD, Baylor College of Medicine, Houston, TX
8:00 a.m.-1:00 p.m. Jenkins/King Room	SC Dermatological Association Scientific Session "Lessons Learned in Cutaneous Oncology" Neil A. Swanson, MD, Oregon Health Sciences University, Portland, OR "Using the New Antifungal Drugs" Richard B. Odom, MD, USCF School of Medicine, San Francisco, CA (Supported by the Dermatology Foundation and underwritten by Neutrogena/Leaders Society Lectureship Program) "What's New in Pediatric Dermatology: Part II" James E. Rasmussen, MD, University of Michigan Medical School, Ann Arbor, MI (Supported by Janssen Pharmaceutica) "Dermatologic Medical Pearls: Part II" Joseph L. Jorizzo, MD, Bowman Gray School of Medicine, Winston-Salem, NC (Supported by Glaxo Dermatology) Grant/Research Support from Ortho, Glaxo, Westwood, Sandoz, Schering. Ortho, Glaxo and Westwood Speaker's Bureaus "Medicare Part B Changes and Billing Issues" (Speaker TBA)

— SCHEDULE OF EVENTS —
Saturday, April 22, 1995 (continued)

TIME/LOCATION	EVENT
8:00 a.m.-12:00 noon Beauregard Room	<p>SC Association of Neurological Surgeons Scientific Session and Business Meeting</p> <p>“Preoperative Interventional Neuro-Radiology for Skull Based Lesions” Joseph A. Horton, MD, MUSC Grant/Research Support: Target Therapeutics, Inc. Consultant: Cordis Endovascular Systems, Inc.</p> <p>“Anterior and Anterolateral Approaches; Case Presentation of Extra and Intradural Tumors” Sunil J. Patel, MD, MUSC</p> <p>“Surgical Anatomy of the Temporal Bone; Case Presentations of Lateral and Posterolateral Approaches” Peter Weber, MD, MUSC Sunil J. Patel, MD, MUSC</p> <p>“Reconstructive Techniques After Skull Base Resection” Marcelo Hochman, MD, MUSC</p> <p>“Review of Skull Base Approaches With Cadaver Prosections” Sunil J. Patel, MD, MUSC</p>
8:30 a.m.-11:30 a.m. Magnolia Ballroom	<p>SCMA Plenary Session</p> <p>“Urinary Tract Infections: A Practical Approach” Charles S. Bryan, MD, USCSM</p> <p>“Infectious Diarrheas: The Old and the New” J. Robert Cantey, MD, VA Hospital, Charleston</p> <p>“Viral Hepatitis: The A Through Zs” Ludwig A. Lettau, MD, Charleston</p> <p>“Tick-Borne Diseases” J. William Kelly, MD, Greenville Hospital System</p> <p>“Sexually-Transmitted Diseases and AIDS/HIV Update” Robert T. Ball, MD, DHEC, Columbia</p>
8:30 a.m.-11:45 a.m. Suite 2H	<p>SC Radiological Society Scientific Session</p> <p>“The KUB in Radiologic Diagnosis” Charles G. Hood, MD, West Columbia</p> <p>“The Elbow: Anatomic-Clinical Correlation” Michael J. Pitt, MD, University of Alabama Health Sciences Foundation, Birmingham, AL</p> <p>“Imaging of Inflammatory Sinus Disease”</p>

— SCHEDULE OF EVENTS —
Saturday, April 22, 1995 (continued)

TIME/LOCATION	EVENT
	John W. Haynes, MD, West Columbia
	“Consensus Quest: One Initiative to Shape a Vision for Radiology” Edward V. Staab, MD, University of Florida College of Medicine, Gainesville, FL
8:30 a.m.-12:30 p.m. Drayton Room	SC Society of Anesthesiologists Scientific Session and Business Meeting
	“Management of the Pediatric Trauma Patient” Jay Masrobian, MD, Richland Memorial Hospital, Columbia
	“Laryngeal Mask Airway: Indications for Clinical Use” Mark L. Pinosky, MD, MUSC
	“Health Care in New England: Changes in the ‘90s” Lizabeth Maloney, MD, Dartmouth Hitchcock Medical Center, Hanover, NH
8:30 a.m.-12:45 p.m. Willow Ballroom	SC Cardiopulmonary Rehabilitation Association Symposium
	“Strategies for Implementing Cholesterol Lowering Diets” Joanne Milkereit, MUSC
	“Medical Treatment of MIs” Bruce W. Usher, MD, MUSC
	“Exercise Prescription—Cardiac and Pulmonary” Mark D. Senn, PhD, SC Heart Center, Columbia
	“Stress and its Effects on Health: A Report from the Dean Ornish Research Project” Sandra McLanahan, MD, Buckingham, VA
9:00 a.m.-12:30 p.m. Fenwick Room	SC Society of Physical Medicine and Rehabilitation Scientific Session and Business Meeting
	“Workers' Compensation Issues in Occupational Injury” Keith F. Holder, MD, MPH, Charleston Steven A. Yuhas, MEd, Mount Pleasant
	“Non-Surgical Management of Shoulder Disorders” Bright McConnell, III, MD, Charleston
	“Beyond Scopes and Blades: The Movie” Richard C. Holgate, MD, Mount Pleasant
	“Pathomechanics of Carpal Tunnel Syndrome and Ergonomic C Considerations” John M. J. Ernst, MD, Charleston

SCHEDULE OF EVENTS

Saturday, April 22, 1995 (continued)

TIME/LOCATION	EVENT
9:00 a.m.-12:00 noon Colleton Room	"The Painful Wrist and Other Soft Tissue Disorders of the Upper Limbs" (aka "So it's just a sprain") James L. Price, Jr., MD, Charleston
	"Recognition of Cervical Radiculopathy and Disc Disorders" Stephen E. Rawe, MD, PhD, Charleston
	Summary Concepts: Question and Answer Session
	SC Chapter of the AAP Scientific Session
	"SCAAP Update" Francis E. Rushton, Jr., MD, President, SCAAP
	"New Approaches to Sickle Cell Disease"
	"Outpatient Management of Fever" Sherron Jackson, MD, MUSC
	"Acute Chest Syndrome" Miguel Abboud, MD, MUSC
	"Reemergence of Group A Streptococcal Disease" Robin Kelley, MD, Greenville Hospital System
9:30 a.m.-11:00 a.m. Edmunds Room	SOCPAC Board Meeting
10:00 a.m.-11:30 a.m. Riley Room	SCIMER Board Meeting
10:00 a.m.-12:00 noon Suite 2G	SC Society of Pathologists Scientific Session
	"New Perspectives in Glomerular Pathology"
	"Focal Segmental Sclerosis"
	"ANCA Associated Glomerular Disease" Deborah M. Milling, MD, MUSC
10:15 a.m.-11:15 a.m. Booths 22 & 65	Coffee Break
11:00 a.m.-1:30 p.m. Gadsden Room	SCMA Sports Medicine Committee Luncheon Meeting
12:00 p.m.-12:30 p.m. Louis's Charleston Grill	SC Radiological Society Reception

SCHEDULE OF EVENTS
Saturday, April 22, 1995 (continued)

TIME/LOCATION	EVENT
12:30 p.m.-3:00 p.m. Magnolia Ballroom	Evaluation and Management of Coding Guidelines Workshop
12:30 p.m.-3:30 p.m. Louis's Charleston Grill	SC Radiological Society Luncheon and Meeting Guest Speaker: K. K. Wallace, Jr., MD, President – ACR "Radiology in the Managed Care Era"
2:00 p.m.-5:00 p.m. Drayton Room	SCMA Committee on Sports Medicine's Scientific Session: Panel Discussion: "Parameters of Returning a Sick or Injured Athlete Back to Participation" Rion M. Rutledge, MD, Rock Hill; J. Rutledge Lawson, MD, Spartanburg; C. Guy Castles, MD, Columbia; Peter J. Carek, MD, Charleston Panel Discussion: "What's New in Sports Medicine" Frank Phillips, MD, Gaffney; Sidney N. Martin, MD, Florence; Fred Hoover, Clemson; Robert M. Peele, MD, Columbia
6:30 p.m.-7:30 p.m. Live Oak Ballroom	SCMA Presidents' Reception
7:30 p.m.-10:30 p.m. Magnolia/Willow Ballrooms	SCMA President's Inaugural Banquet

Sunday, April 23, 1995

7:00 a.m.-10:30 a.m. 2nd Floor Grand Hall	SCMA Registration Open
7:30 a.m.-8:30 a.m. Louis's Charleston Grill	SCMA Board of Trustees Breakfast
8:30 a.m.-12:30 p.m. Dogwood/Cypress/ Live Oak Ballrooms	SCMA House of Delegates
12:30 p.m.-1:00 p.m. Colleton Room	SCMA Board of Trustees Reorganization Meeting



SCMA NEWSLETTER

A PUBLICATION OF THE SOUTH CAROLINA MEDICAL ASSOCIATION

Joy Drennen, Editor

798-6207, in Columbia

Contributions welcomed

1-800-327-1021, outside Columbia

April 1995

HIGHLIGHTS OF THE MARCH BOARD OF TRUSTEES MEETING

The board approved the nominations of Randy Watson, MD, of Aiken; and John Wilson, MD, III, of Conway; to the MIT Board, replacing Dr. Dan Brake whose final term expires next month; and filling the unexpired term of Dr. Bruce Snyder.

The board approved the appointment of Donald Kilgore, MD, of Greenville, to fill a vacancy in District 4 on the SOCPAC Board.

The board voted to support the Blue Ribbon Committee of the Alliance for South Carolina's Children.

In addition, the board met with representatives of the SC Orthopaedic Association regarding SCMA support for introducing a lien law in the state legislature. □

MEDICARE UPDATE

By now you should have received the April, 1995 *Medicare Advisory*. You should read this *Medicare Advisory* carefully. Advisories are published monthly and always contain important information for you and your staff. Included in the April, 1995 *Medicare Advisory* is a complete list of CPT codes which must be filed hardcopy, flu shot update, UPIN information and much more.

Surgery Workshops: Medicare will be conducting workshops for surgical practices throughout the state in June. The preregistration form, locations and dates are included in the April *Medicare Advisory*. All workshops will be held 9:30 am-12:30 pm, with registration beginning at 9:00. The cost is \$20 per person. Seating is limited, so register early.

Specialty Team Concept: Effective April 1, 1995, the Professional Relations Representatives will be assigned to a "Specialty Team" instead of geographic areas. When you call the Medicare Part B Provider Service Center, the ARU

will prompt you to enter your Medicare Provider ID number. Based on the information Medicare has on file for your practice, your call will be transferred to a Customer Service Representative handling inquiries for your specialty. Check the April *Medicare Advisory* for the Professional Relations Representative (PR Rep.) who represents your specialty. The PR Reps. are Michael Thomas, Surgery Team; Louise Mankin, Focused Coverage; and Jody Gibson-Neal, Non-Surgery Team.

1995 Fee Schedule Updates: HCFA has alerted Medicare of updates to the Medicare Fee Schedule Data Base. These updates are effective April 1, 1995, for services rendered on and after January 1, 1995. Medicare will not reopen claims previously paid but will adjust claims which are brought to their attention. See the April *Medicare Advisory* for a complete list of codes.

(Continued on page 2)

LITIGATION REFORM BILL

Fresh on the heels of the U.S. House of Representatives passage of a litigation reform bill, attention now turns to the Senate. Organized medicine, under the leadership of the AMA, achieved a major victory on March 10 when the House voted to pass a litigation reform bill that included a \$250,000 cap on non-economic awards in liability suits (the Cox-Geran amendment) and limits on joint and several liability. Many South Carolina physicians took the time to contact their members of Congress about the bill. South Carolina Representatives Floyd Spence (R), Mark Sanford (R), and Bob Inglis (R) voted in favor of the Cox-Geran amendment. Both Democratic House members and Lindsey Graham (R) voted against the amendment.

Duplicate Payments from Medicaid and Insurance Companies: The Finance Commission recognizes that Medicare is presently sending electronic claims to Medicaid and most supplemental insurance carriers. In many instances, physicians are receiving payments from Medicaid and a supplemental insurance policy, creating a duplicate payment for the coinsurance and deductible portion of your claims.

To eliminate the duplicate payments, Medicaid is in the process of re-activating "cost avoidance" for crossover claims only. Instead of paying the crossover claim, the claim will reject with error code 156 when a Medicare/Medicaid recipient also has supplemental insurance coverage. A bulletin with the details of this change will be received shortly.

Neonatal Intensive Care Codes: The Finance Commission is continuing to work on the implementation of CPT Neonatal Intensive Care (NIC) codes. At this time, however, continue to use the locally assigned "W" codes to report services provided to Medicaid sponsored neonates.

CPT Code Update: Effective April 1, 1995, only the 1995 CPT procedure codes will be accepted by the Finance Commission.

Medicaid Provider Number and Tax Reporting: The Finance Commission assigns each provider enrolled in the program a unique six-digit Medicaid provider number. An individual provider number cross references to an individual's social security number and a group provider number cross references to a federal employer's identification number. Payments are made to the Medicaid provider number as submitted on your claims.

At the end of each calendar year, the total payments made to each Medicaid provider number are reported to the Internal Revenue Service based on the information on the provider's file (either the social security number or federal employer's identification number). It is important that your Medicaid provider files are correct and your Medicaid provider number(s) are correctly entered on all your claims. *If you have any questions concerning Medicaid policy or billing requirements, please call the Department of Physician Services at (803) 253-6134.* □

MEDICARE UPDATE *(continued from page 1)*

Critical Care Codes: HCFA has recently issued clarification for the use of critical care CPT codes 99291 (*Critical care, evaluation and management of the critically ill or critically injured patient, requiring the constant attendance of the physician: first hour*) and 99292 (*...each additional 30 minutes*). HCFA has determined that critical care also includes the care of patients who might not be in a "medical emergency" but who nonetheless require constant physician attention because they are unstable and critically ill, or unstable and critically injured.

The care of such patients involves decision making of high complexity to assess, manipulate and support circulatory, respiratory, central nervous, metabolic or other vital system functions to prevent or treat single or multiple vital organ system failure. It often also requires extensive interpretation of multiple databases and the application of advanced technology to manage the patient. The expanded definition does not mean that the care of a patient who happens to be in a critical care, intensive care or other specialized care unit should be reported with the critical care codes. In such a unit, the care of a patient who is not unstable and critically injured is reported using the appropriate subsequent hospital care code or inpatient consultation code. The time that can be reported as critical care is not limited to time spent at the immediate bedside of the patient. The intent of the terms "constant attendance" and

"constant attention" is to permit the physician to report the time spent engaged in work directly related to the individual patient's care whether that time was spent at the immediate bedside or elsewhere on the floor or unit.

Time spent in activities that occur outside of the unit or off the floor (e.g., telephone calls, whether taken at home, in the office, or elsewhere in the hospital) may not be reported as critical care since the physician is not immediately available to the patient. Time spent in activities that do not directly contribute to the treatment of the patient may not be reported as critical care, even if they are performed in the critical care unit (e.g., telephone calls to discuss other patients). There are no absolute limits on the amount of critical care services that can be billed per day or per hospital. A physician must be prepared to demonstrate that the service billed meets the definition of critical care. Only one physician may bill for a given hour of critical care even if more than one physician is providing care to a critically ill patient.

Critical care cannot be paid on the day the physician also bills a procedure code with a global surgical period unless the critical care is billed with the CPT modifier -25 to indicate that the critical care is a significant, separately identifiable evaluation and management service that is above and beyond the usual pre- and post-operative care associated with the procedure that is performed. □



147TH ANNUAL MEETING AND SCIENTIFIC ASSEMBLY

Omni Hotel
Charleston, SC

As this newsletter goes to press, plans are almost final for the 147th SCMA Annual Meeting and Scientific Assembly, April 20-23, 1995, at the Omni Hotel in Charleston. **Almost 300 physicians have pre-registered as of this date.** If you have not pre-registered, please do so immediately in order to avoid waiting lines at the SCMA registration desk during the actual meeting. Use the registration form which was mailed to you, or clip the form from the March issue of the "SCMA Newsletter."

This issue of *The Journal* contains a wealth of information about the meeting. You may want to note the list of exhibitors which is included, as there are some new and exciting exhibitors in 1995.

Delegates' handbooks were mailed April 4. Delegates, please be sure to bring your handbook to the meeting, or pass it along to your alternate delegate if you are unable to attend. □

SC WORKERS' COMPENSATION 1995 FEE SCHEDULE

Orders are now being taken for the 1995 Medical Services Provider Manual. The 1995 Manual becomes effective May 1, 1995 and replaces the 1990 Schedule of Fees for Physicians and Surgeons. The new fee schedule includes expanded narrative sections that carefully explain billing and payment policy, updated policies for pricing injections and complete instructions for filing Workers' Compensation claims on the HCFA-1500 claim form beginning May 1, 1995. Copies are available for \$25 each, including shipping and handling. *Make your check payable to the South Carolina Workers' Compensation Commission and mail your order to: Medical Services Division, SC Workers' Compensation Commission, PO Box 1715, Columbia, SC 29202-1715.* □

1995 JOURNALISM AWARDS

Congratulations to the following reporters who have been selected as recipients of the SCMA 1995 Journalism Award for Excellence in Health Care Reporting:

- David McIntosh, WPUB/WCAM Radio in Camden, for his report on school health clinics
- Faith Fuller, WIS-TV in Columbia, for her series on "Health Care: Seeking Solutions"
- Karen E. York, *The Times and Democrat* in Orangeburg, for her series on "Healing a Sick System"

The winners will be recognized at an awards ceremony during the SCMA House of Delegates Sunday morning, April 23, 1995. □

ORGAN DONOR AWARENESS WEEK APRIL 16-22, 1995

The nation will celebrate National Organ and Tissue Donor Awareness Week April 16-22, 1995. Hospitals and communities all over the state will be working with the SC Organ Procurement Agency (SCOPA) to provide opportunities for public information to be widely dispersed to the public. Events planned for the week include community donor drives, donor family memorial services, media campaigns and a church bulletin insert campaign reaching over 2,500 congregations in the state.

SCOPA is a federally funded, non-profit organization with offices located in Charleston, Columbia and Spartanburg. SCOPA staff members work very closely with area hospitals to promote teamwork, educate health care professionals about donation and assist in refining policies and procedures for organ donation. SCOPA also provides a wide range of public education services. Last year, the agency's staff participated in over 530 speaking engagements, media events and health fairs. In addition, volunteers who include recipients, donor families, community leaders and health care professionals donate their time and resources to help make their communities more aware of the benefits of donation. The agency also collaborates with various state agencies, legislators, civic and business leaders to promote donor awareness in communities throughout SC.

For more information, contact SCOPA at 1-800-462-0755. □



PALMETTO HEALTH INITIATIVE HOTLINE

Question: If patients have both Medicaid and Medicare coverage, which program will they fall under and how will that be handled? (E. M. Lepine, MD, Rock Hill)

Answer: Patients receiving both Medicaid and Medicare benefits will not be included in the Palmetto Health Initiative. The Palmetto Health Initiative will expand Medicaid eligibility to all people with incomes to 100 percent of the federal poverty level up to age 65.

Palmetto Health Initiative Budget Update: The Palmetto Health Initiative cannot be implemented unless the SC General Assembly appropriates the necessary funds. Currently, the House budget bill includes \$8.9 million to transition the current Medicaid recipients into a managed care system. However, the House budget does not provide funds to expand Medicaid benefits to everyone at or below the federal poverty level. The Senate is in the early stages of debating the budget bill.

Please call the Palmetto Health Initiative Hotline (1-800-825-7821) with your questions or comments regarding the Medicaid waiver. SCMA staff will respond to your question in writing. □

SCMA WORKSHOP CALENDAR

Understanding & Negotiating Managed Care Contracts: In this intensive one day program presented by Stephen P. Williams, JD, Senior Vice President and General Counsel of the SCMA, participants will learn how to read and understand managed care contracts. You will also review the particulars of negotiating contracts, especially medical liability issues. Physicians and office managers will review payment and contracting issues, including capitation, incentives, and point-of-service plans. (Member tuition: \$45.00)

Dates & Locations: June 13, 1995 - Charleston - Charleston Marriott
June 15, 1995 - Columbia - Sheraton Hotel and Conference Center
June 27, 1995 - Greenville - Greenville Hilton
June 29, 1995 - Florence - Florence Civic Center

Appealing Unfair Payments: In this half-day program presented by Practice Performance Seminars, participants will review the reasons for inadequate payments from Medicare and insurance carriers, as well as the tactics you can use to increase your payments or successfully appeal a non-payment. (Member tuition: \$125.00)

Dates & Locations: August 16, 1995 - Columbia - Sheraton Hotel and Conference Center
Two sessions: 9:00 am - 12:00 pm or 1:30 pm - 4:30 pm

Effective Collection Strategies: In this one day seminar presented by IC System, Inc., participants will learn how to collect professionally, using techniques uniquely different from those employed by collection agencies and other third party collectors. Participants will learn how to establish a written collections policy and to maximize the effectiveness of your correspondence, as well as how to keep accounts from becoming delinquent in the first place. (Member tuition: \$150.00)

Dates & Locations: September 20, 1995 - Columbia - Sheraton Hotel & Conference Center

For more information or to register, please call Ginny Comer, extension 253, at 798-6207 in Columbia or 1-800-327-1021 statewide.

WYETH-AYERST PHYSICIAN AWARD FOR COMMUNITY SERVICE

W. Curtis Worthington, Jr., MD, Charleston, has been selected as the recipient of the prestigious Wyeth-Ayerst Physician Award for Community Service. Dr. Worthington was nominated by the Charleston County Medical Society. The award will be presented at the SCMA Annual Meeting during the President's Inaugural Banquet on Saturday, April 22, 1995. □

DELEGATES AND ALTERNATES 1995

ABBEVILLE	A. Grady Oliver, MD	Christine Lloyd, MD
AIKEN	<i>Not available at press time.</i>	Edward C. Morrison, MD
ALLENDALE	Thomas B. Warren, Jr., MD	Samuel Rosen, MD
Alternate:	Keith Young, MD	David K. Smith, MD
ANDERSON	Stuart Barnes, MD	John F. Sorrell, MD
	William Buice, MD	James E. Warmoth, MD
	Peter Cook, MD	Henry West, MD
	Len Douglas, MD	G. Frederick Worsham, MD
	Clayton Gibson, MD	<i>Not available at press time.</i>
	Tom Tuten, MD	CHESTER
	Jim Walker, MD	Sam Stone, MD
BAMBERG	<i>Not available at press time.</i>	CHESTERFIELD
BARNWELL	<i>Not available at press time.</i>	Winston Godwin, MD
BEAUFORT	<i>Not available at press time.</i>	Frank Biggers, MD
BERKELEY	S. O. Schumann, Sr., MD	Michael Hawkins, MD
Alternate:	S. O. Schumann, Jr., MD	COLLETON
CHARLESTON	David Adams, MD	Eloise A. Bradham, MD
	J. Gilbert Baldwin, Jr., MD	Stacey Brennen, MD
	Nabil K. Bissada, MD	Charles S. Bryan, MD
	Julian T. Buxton, Jr., MD	C. Guy Castles, III, MD
	William T. Creasman, MD	Belton D. Caughman, MD
	Bertram C. Finch, MD	Vincent J. Degenhart, MD
	Richard Gross, MD	Myles D. Davis, MD
	Lucinda Halstead, MD	Alexander G. Donald, MD
	D. Michael Hull, MD	John L. Eady, MD
	Marc Kolender, MD	Kathleen P. Flint, MD
	Clarence W. Legerton, III, MD	Frampton W. Henderson, MD
	G. T. Little, MD	Dixie J. Hines, MD
	Leonard Lichtenstein, MD	Warren F. Holland, MD
	Michael A. Maginnis, MD	Edward E. Kimbrough, MD
	Bright McConnell, III, MD	Lawrence Klein, MD
	Alan Nussbaum, MD	David Koon, MD
	Baird D. Oldfield, MD	Robert Malanuk, MD
	Demetrios Papadopoulos, MD	M. F. McFarland, MD
	William Rambo, MD	William R. McWilliams, MD
	Alexander W. Ramsay, MD	Robert N. Milling, MD
	Allan Rashford, MD	William J. Neglia, MD
	Daniel Ravenel, MD	Herbert B. Niestat, MD
	Carolyn Reed, MD	John Popp, MD
	Frederick Reed, MD	James C. Reynolds, MD
	Edmund Rhett, Jr., MD	James W. Stands, MD
	Rudolph Rustin, MD	Charles N. Still, MD
	Eugene D. Rutland, MD	Melton R. Stuckey, MD
	Robert Sade, MD	C. Alden Sweatman, MD
	Kenneth Spicer, MD	Nguyen D. Thieu, MD
	Mike O. Tyler, MD	John L. Ward, MD
Alternates:	Thomas C. Appleby, MD	Gerald A. Wilson, MD
	Paul Baron, MD	Alternates:
	H. Wade Boatwright, MD	Silvia Bloch, MD
	Bruce M. Elliott, MD	Raymond Bynoe, MD
	Lydia A. Engelhardt, MD	Lilly Filler, MD
	Robert W. Fitts, MD	Jeffrey Gross, MD
	Dennis Fried, MD	Satish Prabhu, MD
	George D. Grice, MD	Victoria Samuels, MD
	John R. Hardy, MD	Glen Strickland, MD
	Russell A. Harley, MD	DARLINGTON
	Janice Key, MD	<i>Not available at press time.</i>
	Christopher Lahr, MD	DILLON
	Levern Livingston, MD	Swift Black, Sr., MD
	Thomas Leland, MD	Alternate:
		Suzanne G. Black, MD
		DORCHESTER
		<i>Not available at press time.</i>
		EDISTO-ORANGEBURG
		Richard Carpenter, Jr., MD
		Walter E. Conner, MD
		Steve Patterson, MD
		FAIRFIELD
		Anil J. Kudchadkar, MD

DELEGATES AND ALTERNATES

Alternate:	William Burnham, MD	Ed Robinson, MD
FLORENCE	J. P. Booth, MD	Richard Young, MD
	William Boulware, MD	<i>Not available at press time.</i>
	Bill Edwards, MD	<i>Not available at press time.</i>
	Mark Fox, MD	Donna P. Smith, MD
	James Hammond, MD	<i>Not available at press time.</i>
	Ashley Kent, MD	Gwendolyn Cambron, MD
	Sidney Martin, MD	F.W. Clemenz, MD
	James Mock, MD	Robert L. Galphin, MD
	Berry Monroe, MD	G. Tripp Jones, MD
	Steve Ross, MD	Thomas W. Messervy, MD
GEORGETOWN	Gerald E. Harmon, MD	Frank W. Young, MD
	Lowell R. McClary, MD	Alternate: Hank Powell, MD
	Wright S. Skinner, MD	MARION Hugh V. Coleman, MD
Alternate:	Tom Cerasaro, MD	Alternate: Kamil S. Basily, MD
GREENVILLE	Joy S. Anglea, MD	MARLBORO Dell A. Dembosky MD
	J. Duncan Burnette, Jr., MD	Alternate: Paul Zabel, DO
	Bradford S. Collins, MD	NEWBERRY <i>Not available at press time.</i>
	William R. Craig, III, MD	OCONEE Edward Booker, MD
	John B. Eberly, MD	James Cochran, MD
	Sutton L. Graham, II, MD	Jim Pruitt, MD
	Donald G. Gregg, MD	Alternates: A. T. Crowe, MD
	Raymond V. Grubbs, MD	Don Richardson, MD
	Lyn H. Hammond, MD	Randy Wendt, MD
	Lloyd E. Hayes, MD	PICKENS Karen Ardis, MD
	Wayne M. Hollinger, MD	R. H. Bowick, MD
	William B. Jones, MD	Jake Holcombe, MD
	Donald G. Kilgore, Jr., MD	Brad Simpson, MD
	J. Rutledge Lawson, MD	Boyce Tollison, MD
	Woodrow W. Long, Jr., MD	Larry W. Winn, MD
	Joseph C. McAlhany, Jr., MD	Alternate: Sandra Lamberson, MD
	T. Wayne McDonald, MD	RIDGE W. Hugh Morgan, MD
	James B. Page, MD	SPARTANBURG Sami Elhassani, MD
	James A. Robbins, MD	Mukesh Gandhi, MD
	Ted J. Roper, MD	John W. Johnson, MD
	John R. Sanders, MD	Joe Kavanagh, MD
	John R. Satterthwaite, MD	Ann Kelly, MD
	Pam S. Snape, MD	Harry Kinard, MD
	Bruce A. Snyder, MD	Sam Reid, MD
	Jesse R. Stafford, MD	Mark Visk, MD
	Joseph H. Wentzky, MD	Auburn Woods, MD
	Morris E. Williams, Jr., MD	SUMTER-CLARENDON-LEE
Alternates:	Eric J. Baker, MD	Linwood G. Bradford, MD
	James C. Raff, MD	Norman B. Clinkscales, MD
	Michael D. Stamm, MD	Jim Ingram, MD
GREENWOOD	John Funke, III, MD	UNION <i>Not available at press time.</i>
	Greg Mappin, MD	WILLIAMSBURG Howard Poston, MD
	Preston Turner, MD	Alternate: Harry Floyd, MD
	Ted Vaughn, MD	YORK <i>Not available at press time.</i>
	Paul Velky, MD	S. C. SOCIETY FOR ALLERGY & CLINICAL
	Bill Warner, MD	IMMUNOLOGY
HAMPTON	<i>Not available at press time.</i>	Bruce D. Ball, MD
HORRY	John Charles, MD	Alternate: David Perrick, MD
	Paul Cohen, MD	S. C. SOCIETY OF ANESTHESIOLOGISTS
	Glenn Gangi, MD	Edwin A. Bowe, MD
	Edward Hayes, MD	Alternate: Gordon L. Langston, MD
	John Molnar, MD	S. C. CARDIAC & THORACIC SURGICAL SOCIETY
	Eric Senn, MD	<i>Not available at press time.</i>
	Eston Williams, Jr., MD	S. C. DERMATOLOGICAL ASSOCIATION
Alternates:	Marc Binard, MD	Kenneth R. Warrick, MD
	William Greene, MD	S. C. COLLEGE OF EMERGENCY PHYSICIANS
	Kimberly Goh, MD	No Delegate

DELEGATES AND ALTERNATES

S. C. ACADEMY OF FAMILY PHYSICIANS	Stoney A. Abercrombie, MD	Michael Bubel
Alternate:	Albert D. Mims, MD	USC MEDICAL STUDENT SECTION PRESIDENT
S. C. SOCIETY OF INTERNAL MEDICINE	F. Kay Huntington, MD	Larry R. Faulkner
S. C. ASSOCIATION OF NEUROLOGICAL SURGEONS	<i>Not available at press time.</i>	PARLIMENTARIAN
S. C. NEUROLOGICAL ASSOCIATION	No Delegate	James Ingram, MD
S. C. SECTION, AMERICAN COLLEGE OF OB/GYN	Salvatore Rini, MD	SPEAKER OF THE HOUSE OF DELEGATES
S. C. ONCOLOGY SOCIETY	John S. Ravita, MD	Roger A. Gaddy, MD
S. C. SOCIETY OF OPHTHALMOLOGY	Thomas A. Whitaker, MD	VICE SPEAKER OF THE HOUSE OF DELEGATES
Alternate:	Lowrey P. King, MD	William H. Hester, MD
S. C. ORTHOPAEDIC ASSOCIATION	James H. Hill, Jr., MD	TWO IMMEDIATE PAST PRESIDENTS
Alternate:	James J. McCoy, Jr., MD	Edward W. Catalano, MD
S. C. SOCIETY OF OTOLARYNGOLOGY, HEAD AND NECK SURGERY	James R. Wells, MD	Bartolo M. Barone, MD
Alternate:	Warren Adkins, MD	PHYSICIAN MEMBER OF THE DHEC BOARD
S. C. SOCIETY OF PATHOLOGISTS	Hans K. Habermeyer, MD	<i>Not available at press time.</i>
S. C. CHAPTER, AMERICAN ACADEMY OF PEDIATRICS	Francis Rushton, MD	REPRESENTATIVE, STATE BOARD OF MEDICAL EXAMINERS
Alternate:	Dane Pierce, MD	C. Dayton Riddle, MD
S. C. CHAPTER, AMERICAN COLLEGE OF PHYSICIANS	No Delegate	AMA DELEGATES
S. C. SOCIETY OF PLASTIC & RECONSTRUCTIVE SURGEONS	Steven K. White, MD	Daniel W. Brake, MD
Alternate:	Samuel Matthews, MD	Charles R. Duncan, Jr., MD
S. C. PHYSICAL MEDICINE & REHABILITATION	Greg Jones, MD	J. Chris Hawk, III, MD
Alternate:	Tracy Lynn McFall, MD	Walter J. Roberts, Jr., MD
S. C. PSYCHIATRIC ASSOCIATION	No Delegate	AMA ALTERNATE DELEGATES
S. C. RADIOLOGICAL SOCIETY	H. W. Sanford, MD	Roger A. Gaddy, MD
Alternate:	Robert J. Caswell, II, MD	Stephen A. Imbeau, MD
S. C. CHAPTER OF THE AMERICAN COLLEGE OF SURGEONS	No Delegate	John W. Simmons, MD
S. C. SURGICAL SOCIETY	<i>Not available at press time.</i>	S. Nelson Weston, MD
S. C. THORACIC SOCIETY	No Delegate	SCMA BOARD OF TRUSTEES
S. C. UROLOGICAL ASSOCIATION	<i>Not available at press time.</i>	O. Marion Burton, MD, President
S. C. VASCULAR SURGICAL SOCIETY	Daniel Rush, MD	Benjamin E. Nicholson, MD,
Alternate:	William M. Moore, MD	President-Elect
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Alternate:	Mark Lyles, MD	Richard E. Ulmer, MD, Trustee,
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USC MEDICAL STUDENT SECTION PRESIDENT		John B. Johnston, MD, Trustee,
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		Vasa W. Cate, MD, Trustee, Second
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		George P. Cone, Jr., MD, Trustee,
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		Patricia P. Westmoreland, MD,
		Trustee, Fourth District
		Jerry R. Powell, MD, Trustee,
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		R. Duren Johnson, Jr., MD, Trustee,
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		Kenneth L. DeHart, MD, Trustee,
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		Sompong Kraikit, MD, Trustee,
		Sixth District
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		Seventh District
		Dallas Lovelace, III, MD, Trustee,
		Eighth District
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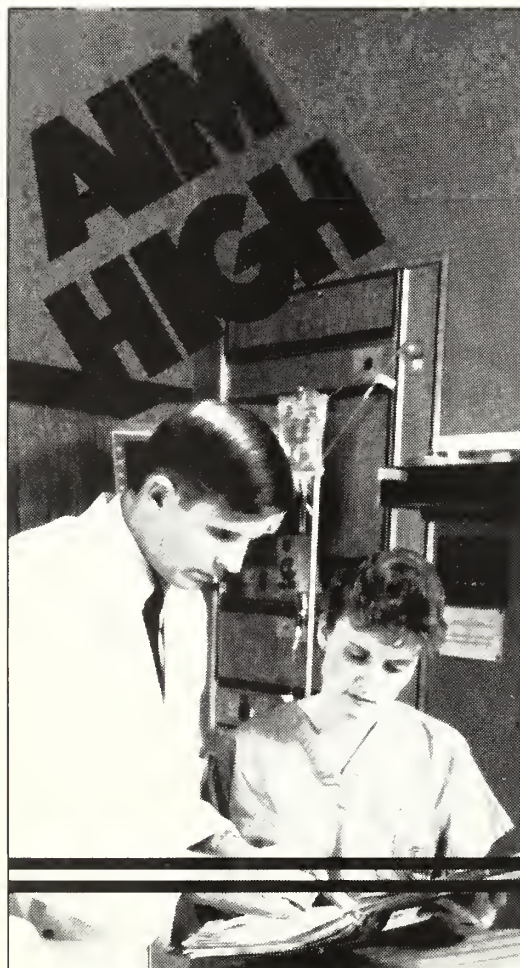
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THE PRESIDENT

The same Yogi Berra who said "It ain't over 'til its over" is also attributed as having stated "I want to thank everyone who made this day necessary." Well, my term as your president is almost over and I want to thank you, my colleagues, who made this year most remarkable for me. It has been a distinct honor to serve you, our beloved profession, and our patients. This is a time which has been filled with great experiences that will result in lasting memories. More importantly, I trust that the days have been productively spent for the House of Medicine in South Carolina. The accomplishments of the South Carolina Medical Association (SCMA) in the last 12 months are due largely to a committed, talented and diligent staff, Board of Trustees and committee leadership. In fact, our SCMA is extremely effective and well-positioned to carry us into and through this period of rapid change for our profession. I am pleased to recount the year's momentum for you. Our own managed care product, Physicians Care Network, has three large contracts, two statewide and one area-specific. Self-insured employers all over South Carolina are demonstrating an intense interest in our plan and I predict that the number of participating institutions and covered lives will increase rapidly and dramatically. Barbara Whittaker, Senior Vice President, and George O'Laughlin, Director of Marketing, are to be commended for their perseverance, dedication and enthusiasm. Our network still needs you to be successful. If you have not enrolled as a participating provider, please do so now. Remember, this is your managed care company.

The South Carolina Institute for Medical Education and Research (SCIMER) has successfully implemented the Section 170 program that allows you to accumulate additional tax-advantaged retirement savings. There are over 17 million dollars in annuity/insurance accounts which will benefit SCIMER's efforts as well as supplement the retirement incomes of participating SCMA members. To take advantage of this unique benefit, call Brian Bock or Richard

Howard at the SCMA Headquarters.

You demonstrate your unselfishness and caring by continuing to increase participation in Commun-I-Care. To date over 900 physicians have served over 8,000 needy citizens of South Carolina. Many doctors report great satisfaction in treating these patients, and the staff and organization of the project make the mechanism as painless and trouble-free as possible for individual practices. For more information or to enroll as a contributing provider, call Commun-I-Care at 1-800-763-0059.

Medicaid is a large payor of health care in South Carolina. Through the pending Palmetto Health Initiative (PHI), over 600,000 enrollees will be placed in managed care arrangements. If this program is implemented in 1996, it will have a dramatic effect on the health insurance market in the Palmetto State. There are a score of health maintenance organizations (HMOs) in various stages of the application process to the South Carolina Insurance Commissioner for licensure to do business in the state. For many of them, the first product will be the PHI because of the vast numbers of new covered lives and the probability that these new (to SC) companies can attract significant numbers of these enrollees. With this core of financial base, the HMOs can then pursue other marketing opportunities with South Carolina industries, businesses and governmental entities. Physicians will be able to participate in PHI through these managed care contracting intermediaries and/or directly with the Health and Human Services Finance Commission (HHSFC/ the Medicaid agency) via a mechanism called the Physicians Enhanced Program (PEP). This model capitates the primary care physician at a fixed monthly sum for providing routine care and pays fee-for-service to all other specialists. This arrangement does not involve an intermediary HMO and could have fewer complexities. The SCMA has asked for a third option for physician participants and that is a fee-for-service model with a nominal monthly management fee (\$4 or so) for the primary care doctor to actually provide some gatekeeper services. Thus far this fea-

ture is not in the proposal. Your staff and leadership have been actively involved in the development of PHI for over 18 months. HHSFC and the Governor's office have been receptive to our input and actively seek our advice. With continued collaboration, the upheaval experienced in the TennCare program can be avoided. The PHI must not become financially and administratively crippling to South Carolina doctors, and your staff is monitoring developments closely. Meanwhile, please consider becoming a participating provider in one or both of the options (HMO and PEP) when this program is implemented sometime in 1996. If you have questions or seek more information about PHI, please call the SCMA's special hotline number, 1-800-825-7821. Staff will respond to your questions and/or comments and publish questions of particular interest to the membership in the "SCMA Newsletter." It is important that physicians assume a leading role in the further development and implementation of this mammoth change in health care delivery for many South Carolinians.

Your Board of Trustees and staff have been considering alternatives to assure that the patient/physician relationship is preserved in the shift to a health insurance market in which managed care companies have more dominance. At the SCMA House of Delegates (HOD), several proposals will be introduced for consideration, including a Managed Care Improvement Act and a Patient Choice Bill. If the HOD consensus is to pursue legislation, the proposal will be introduced in the 1996 General Assembly. The House of Medicine in South Carolina, however, must be unified and committed to this effort in order for it to succeed.

SCMA Financial Services, Inc. is solidly profitable and experiencing rapid growth. As SCMA members, we can contribute to the success of our organization simply by purchasing our professional liability, life, disability, property/casualty, and other insurance needs through this subsidiary. The products offered are attractively priced due to volume purchases and, in many cases, designed specifically for physician lifestyles and preferences. Please call Vic Paschal or Nancy Canniff when you have insurance

needs or questions.

SCIMER received a highly competitive Robert Wood Johnson Foundation Reach Out grant to link private practicing physicians with local public health departments in order to provide medical homes for more children in underserved areas. SCIMER's program, PARTNERSHIPS FOR CHILDREN, allows the doctor to care for more patients by utilizing public health providers for support services. This public/private partnership efficiently utilizes local resources while keeping health care where it belongs – in the physician's office. This is truly placing the well-being of the patient and community first.

The Inter-Specialty Council consists of representatives from specialty societies in the SCMA House of Delegates, who focus on health-related bills currently debated in the South Carolina Legislature. During the council's meetings, there has been some consensus, some disagreement, and in every instance a greater awareness and understanding of differing views. More importantly, issues of quality, access to and affordability of health care have permeated the discussions. SCMA members and specialty society physicians can be justly proud that their representatives are putting patient interest high on each agenda item. The potential is enormous for this forum to unify our profession around advocacy for those we serve.

There is an exciting new partnership developing between the SCMA and the South Carolina Hospital Association (SCHA). Selected members from both Boards of Trustees, along with appropriate staff, are exploring ways hospitals and physicians can combine energies to better serve patients and communities. With these two dominant health care organizations in any South Carolina locale focusing on access, quality and cost, progress is likely.

Finally, I am pleased to report that the SCMA is positioned to be a strong and enduring resource to our profession as we enter these turbulent times. Membership has increased by over 600 physicians in the past 12 months. This 18 percent growth is incredible for a medical association. The staff is talented, focused and energetic. Our finances are sound and the new subsidiaries

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are profitable. Our Chief Executive Officer, Bill Mahon, is respected nationwide for his astute management, innovative products, legislative acumen, and staunch advocacy for medicine. We have an outstanding Board of Trustees and a stalwart chairman in Dr. Nelson Weston. SCMA committee leadership is as strong as I have ever seen. Under the leadership of Dr. Walt Roberts, an AMA Delegate, South Carolina continues to be well-respected from coast to coast. Dr. Randy Smoak, the first South Carolina physician in 30 years to serve on the AMA Board of Trustees, has represented us in a most esteemed fashion. I am honored to have served with the finest. Dr. John Preston in *The Recorder* states "All that is past is prologue-which means you ain't seen nothing yet." I leave this office with a clear conviction that with this caliber of organization supporting South Carolina physicians, "You really ain't seen nothing yet." Thank you for allowing me to serve as your 131st President.

O. Marion Burton, MD
President

THE SECRETARY

The past year has been very good for South Carolina Medical Association (SCMA) membership growth. While the total number of physicians eligible for membership has decreased from 6,640 to 6,612, the number of SCMA members has increased from 3,672 to 3,977. This gives us a 60.1% membership total compared to 55.3% at this same point in time last year. This percentage is well above the national average. While this increase is partly due to the requirement of SCMA membership in order to be a member of the Physicians Care Network (PCN), I would like to think that some of the increase is due to a growing awareness of the importance of participation in organized medicine. I think this is reflected in the increase in membership of South Carolina physicians in the American Medical Association (AMA). We have 1,963 members this year as compared to 1,925 at this time last year.

Although the above statistics would seem to indicate a bright future for the SCMA, there are other factors which may indicate the opposite.

More and more specialty and sub-specialty groups are isolating themselves and attempting to "go it alone." This is especially true when negotiating with HMOs, PHOs and other reimbursement entities. This also appears to be the case in dealing with the legislature. While this approach may be expedient and rewarded with initial financial gains, the long-term effects may be disastrous. A very successful tactic in war is to divide and conquer. By dividing ourselves we are aiding and abetting the control of medicine by entities other than those who should rightfully be in control – the physicians themselves.

While there are wide differences between specialties in regard to workload, time off and reimbursement, I feel there is a great deal of common ground between us. Change is definitely coming and to some it may well be very painful. But by working together, with a lot of give and take, I feel we can make these changes a lot less painful, preserve organized medicine and keep control of medicine in the proper hands.

Our President, Dr. Marion Burton, has initiated an Inter-Specialty Council which offers an excellent forum for the problems facing our specialties, as well as medicine as a whole. The initial meeting has been well attended and well received. Please encourage the leadership of your specialty to attend and participate in this very important and timely council.

I would like to encourage you to become a participating physician in the PCN if you have not already done so. I believe we have a fine product to offer the business community and our commitment to it will ensure its success.

Thank you for allowing me to serve as your secretary this year and I look forward to working with you in the future to make the SCMA as strong as it can be.

Bryan L. Walker, MD
Secretary

THE TREASURER

As I complete my first year as treasurer of the South Carolina Medical Association (SCMA), I would like to present a short report about the SCMA's financial condition. A more comprehensive report will be presented to the 1995

House of Delegates in Charleston.

For the year ended June 30, 1994, the SCMA had net expenses over revenue including depreciation of \$160,857.00. However, if one excludes depreciation expense of \$42,691.00, the SCMA had net operating expenses over revenues of \$118,166.00. The SCMA had a Fund Balance of \$1,341,887.00 as of June 30, 1994.

The SCMA's current financial condition for the eight months ended January 1995 projects a positive financial position. At the end of January, the SCMA had revenue over expenses of \$111,277. We currently project that the SCMA will have an excess of revenue over expenses for this fiscal year.

The investment policies of the SCMA and its affiliates have continued in a similar manner, as in past years, with diversified investments in federal treasury and agency notes and money market funds.

For several years, SCMA's policy has been to maintain total reserves equal to one year's operating budget. The organization's yearly budget has grown to such a large amount that such reserves are considered excessive by good business standards. The Board of Trustees voted in September and set the total reserves at or above \$1 million. That change has allowed SCMA to provide for starting expenses to PCN to be returned as PCN becomes profitable.

We have a history of operating on a sound financial basis and we should continue to do so.

For the fiscal year ending June 1996, we project a surplus of revenue over expenses.

I thank the membership for the privilege of serving as your treasurer for the past year.

Carol S. Nichols, MD

Treasurer

THE CHAIRMAN OF THE BOARD

Your board has witnessed a surprising year in health care. At this time last year, who would have predicted the collapse of the Clinton health care proposal and the Republican landslide victory in November. With these events the status of government health system reform has taken a back seat and only incremental reforms are being suggested. Certainly these are not priority items in

Washington. Despite these events, health system reform continues to take place but much more so on a local or statewide level. Managed care is making its way into every community and this is obviously where real reform is taking place. Your board has witnessed these magical events sometimes having difficulty believing what we were seeing, but always deciphering, adapting, and modifying our decisions to do what was in the best interest of our patients and profession. To emphasize the environment in which we are working, I would like to point out to you the Palmetto Health Initiative (the Medicaid waiver) which has been approved by HCFA. Although it will affect over a half million South Carolinians and every physician provider in the state, it has not yet been funded by the legislature or approved by the governor and the Budget and Control Board. At the time of writing this report, no one in South Carolina knows whether this plan will be implemented or not.

Despite these difficult times, your board has been diligent in following the House of Delegates directions and ensuring that the South Carolina Medical Association (SCMA) continues to be a significant or leading player in the economics and politics of health care in this state. Following the House of Delegates instructions, we became part of a coalition that has developed legislation for smoke-free schools and incorporated the licensure of tobacco sales into this legislation. We have been vocal in our decision to oppose all elective home deliveries and to rescind the licensure of lay midwives. Your board, in cooperation with the South Carolina Hospital Association, has formed a Health Care Policy Committee which will ensure that providers work together for the benefit of patients in the new health care environment.

We made an important decision to reduce our operating reserves to one million dollars as opposed to a year's budget (one and half a million dollars) in order to fund Physicians Care Network. In regards to PCN, we remain confident that this will be a successful venture and we are all pleased with Barbara Whittaker's leadership in this area.

At the 1994 Annual Meeting, the House of Del-

legates asked us to consider several resolutions and report back to them in 1995. In the past we have simply reported the board's action in the Chairman's report. This year there will be several independent reports that will be considered by the House of Delegates. This is being done because of the complexity and importance of the issues and we hope that this method of reporting will meet with your approval. Examples of these are, Report B-23, Patient Access to Dermatological Care; Report B-25, Any Willing Provider Legislation; and Report B-24, School-Based Health Clinics. This method of reporting is similar to the AMA board's handling of their reports. The reference committees and the House of Delegates will be given specific instructions from the Speaker of the House on how these reports should be handled.

I would like to emphasize Report B-25, Any Willing Provider Legislation, which is perhaps the most important issue of the day. We were instructed to develop and introduce legislation which would ensure patients' rights to choose their physicians and physicians' rights to participate in a managed care environment. This has been done and the Managed Care Improvement Act is being presented to you in the form of a report. Our plan was, and remains, to present this document at the Annual Meeting, get unanimous support and take it to the legislature. Because of the political situation, we knew getting this legislation passed would take a grassroots effort with each member of the SCMA taking an interest and encouraging his or her individual legislator to support the bill. Anything less would diminish the chances of the bill passing. Our plans were to mount this effort over the next year and pass the bill in 1996. However, our best laid plans were interrupted this year when Senator McConnell of Charleston introduced Senate Bill 384, a point-of-service bill, (in some ways stronger than ours but with potential flaws) that we could support. At the newly formed Inter-Specialty Council, the bill was presented and we were unable to get unanimous approval of this bill. Without unanimous approval we believe that the bill will not pass. Our decision remains to bring our bill to you, get overwhelming approval,

and take it to the legislature next year. Please understand that staff, lobbyists and board will not be enough in this undertaking. For this bill to be successful, it will take each of you to make an extraordinary effort. You must contact members of the legislature by politicking, cajoling and doing whatever else is ethically correct in obtaining their vote.

Please bear in mind that sometimes what appears to be the best for you and your specialty may not always be what is in the best interest of the entire profession over the long haul. We should always put our patients first, maintaining our ethics and professionalism. Our opponents know how to divide and conquer. Let's not make it easy for them. We must show them a united front. Do not forget that the SCMA represents the entire federation of physicians in this state and accordingly our charge is to act in the best interest of our entire profession.

In closing, it is a special privilege to work with Bill Mahon and his staff. No words can express my admiration for Bill. He is at the top of his profession on a national and state level. We are indeed fortunate to have him.

I thank all of you for allowing me to serve. At the end of our Annual Meeting we should know our direction. Let's get together and get it done.

S. Nelson Weston, MD

Chairman of the Board

THE SPEAKER OF THE HOUSE

The 147th Annual Meeting & Scientific Assembly of the South Carolina Medical Association (SCMA) will be held April 20th through April 23rd, 1995, in the Omni Hotel at Charleston Place. The schedule for the clinical sessions, social gatherings, and the House of Delegates has been carefully arranged to allow you to participate in all activities to the fullest extent. Dr. Jim Haynes and the Continuing Medical Education Committee have arranged an outstanding array of speakers to update us in various aspects of medicine. We will have Plenary Sessions on "Infectious Disease," "Changes in Health Care," and the "What's New In" session on Thursday afternoon that will present a variety of topics in condensed 20-minute lectures. In addition, there

will be a workshop on "Recognition and Prevention of Adolescent Alcohol and Drug Use" and also a scientific session presented by the SCMA Committee on Sports Medicine. At least 12 specialty societies will also have scientific sessions which will offer updates on a wide variety of subjects. Fourteen CME credit hours can be obtained beginning Thursday afternoon and extending through Saturday afternoon.

Special guests for the week will include Dr. Richard Corfin, Vice-Speaker of the American Medical Association (AMA) House of Delegates; Dr. Thad Wester, President of the North Carolina Medical Association; Dr. Bob Lanier, President of the Georgia Medical Association; and Dr. Lewis Cancellaro, President of the Southern Medical Association; also Dr. James White representing the American Political Action Committee (AMPAC). On Saturday evening at the inaugural banquet, we will honor Dr. Benjamin (Ned) Nicholson. The cost of the inaugural banquet is being subsidized this year, and tickets will be at a reduced rate. We encourage all attendees to attend the banquet, which should conclude early enough Saturday night to allow extra free time to "go out on the town."

Your Board of Trustees, officers and staff have worked hard this year to implement those resolutions and recommendations adopted by the House of Delegates at its 1994 meeting. The status of these actions is included in a lengthier version of my report to the House of Delegates. At the 1994 meeting, you asked that the SCMA encourage all state buildings, including athletic facilities, be declared smoke-free, and a letter was sent to Governor Carroll Campbell making that request. Also, a joint letter from the SCMA and the South Carolina Academy of Pediatrics was sent to the South Carolina Secretary of Education, Barbara Neilsen, asking that all 92 school districts in South Carolina be tobacco-free for students and teachers. Also, the SCMA is continuing to work with the AMA to repeal the onerous regulation of the Clinical Laboratories Improvement Act.

Items referred to the Board of Trustees for report back in 1995 include a report on school-based and school-linked clinics, physician care

responsibility and direct access to dermatological care. As you peruse these House actions from last year and listen to various staff and officers' reports, including that of our chief executive officer, you will undoubtedly see the direction you set for our association has resulted in numerous successes this past year.

Our profession, through its grass roots organization, SCMA and AMA, helped influence our congressmen and senators to realize that the last thing American medicine needs is another government-run bureaucracy. Your president, president-elect and board chairman, along with key staff members, have accessibility and credibility with our congressional delegation in Washington. Their input to these congressmen and senators will continue to influence the health system debate. As we review our progress this past year, we owe a great debt of gratitude to our hard-working Chief Executive Officer, Mr. Bill Mahon, and his staff who serve us so well. Without the hard work and dedication of these men and women, we would not have our efficient, successful organization. When you see them at this meeting, I encourage you to thank them for all that they do, for all of us.

The SCMA House of Delegates is a forum to present our individual and collective view points. As resolutions are debated in reference committees and on the house floor, our decisions should be based on sound analysis of these issues and consequences, ever mindful that the decisions we make will impact patients and physicians in South Carolina. I am proud to be a member of the AMA, the SCMA and the South Carolina House of Delegates. Thank you, again, for letting me serve.

Roger A. Gaddy, MD
Speaker of the House

TRUSTEE, FIRST MEDICAL DISTRICT

It has been my pleasure to serve on the Board of Trustees as rural trustee for the First Medical District. Again, it has been an exciting and, I think, a most productive year.

Locally we have been able to recruit some new physicians in Colleton County. I have talked to these new physicians about joining the SCMA and

also about enrolling in the Physicians Care Network. I feel that in the rural districts we are doing a good job of recruiting the active physicians on the medical staff and in the community.

The most productive business initiated by the Board of Trustees for the physicians in the rural First Medical District has been the Physicians Review Organization (PRO) no longer badgering our hard-working physicians who are delivering quality health care in the rural district. The PRO was taking up much of our time locally, as it was in the more urbanized areas, and this has been one matter that the physicians of the first district have appreciated most.

I look forward to continuing to support the SCMA and working as diligently as I can not only for the physicians of the First Medical District but for all the physicians in the state.

John B. Johnston, MD

Trustee, First Medical District

TRUSTEE, FIFTH MEDICAL DISTRICT

In the late 60s Alan Arkin made a movie entitled "The Russians are Coming! The Russians are Coming!." For the counties of district five and especially for York County a new scenario is unfolding which could be called "Managed Care is Coming! Managed Care is Coming!." The physicians of Rock Hill are watching this feature right now.

The *Charleston Post and Courier* (Friday, February 3, 1995)¹ ran a column by Joan Beck entitled "Doctors Should Decide Healthcare's Future." In the column Mrs. Beck points out that the managed care changes wrought in the health care environment are "deadly scary." She laments that hospitals are cutting nursing staffs, lowering the level of patient care and substituting other care givers with less training and lower pay. In an effort to reduce medical cost to the minimum possible for patients (read here corporate providers and insurance companies) in order to wring the maximum amount of money possible out of the system. Many physicians are losing their economic autonomy and professional independence in the newly emerging Wal-Mart world of corporate managed health care. Politicians, administrators, employers, insurance companies

and the financial markets are shaping the future of health care, not physicians. The emphasis is no longer on humanitarianism or healing but rather efficiency, perhaps even by taking risks with patients' health. It will be increasingly hard for physicians to keep patient trust and goodwill in the new regimes of cost controls, practice parameters, and bureaucratic red tape, corporate or governmental.

In 1994, P. John Seward, MD, chair of the American Medical Association (AMA) National Committee on Managed Care presented a report² to the National AMA Board of Trustees. Some of the facts contained therein are truly scary and merit every physician's attention, contemplation, and personal and professional action. In the paragraphs that follow, I would like to summarize and present some of this information for our consideration.

The current health care environment is extremely uncertain and it is virtually impossible to predict how health care plans, health care delivery, and physicians will be organized and regulated even five years from now. Maximum flexibility and adaptability on the part of physicians will be required if any of us are to salvage our career, much less income.

Two major trends occurring both nationally and locally will act to transform the health care landscape as we know it: first, there is ongoing development of managed care plans relying increasingly on tightly organized and structured health care delivery systems, and second, there is an avalanche of health system reform legislation at state and federal levels. Regardless of governmental initiatives, the evolution and increasing reliance on managed health care for delivery, especially Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) type systems, will continue.

Figures for 1992 and 1993 are the most complete ones currently available. At least 44 million or 16.3% of the population is currently enrolled in 550 HMOs and over 50 million are enrolled in 880 PPOs. HMOs offering a point of service option have increased membership over 44% in recent years. Enrollment in HMO and PPO organizations tends to be concentrated in

large HMOs in larger urban areas with mature managed care markets. Their growth is facilitated by the presence of large employers, adequate numbers of beneficiaries to achieve economy of scale and actuarial predictability along with a large enough concentration of health care providers to form health care delivery networks. HMO/PPO providers often accelerate their growth through market dominance and using their leverage to the extract cost reductions from hospitals, physicians and others. Often one or two large managed care organizations or insurance companies will dominate 30% to 75% of the market. Nearby Atlanta has at least 10 HMOs and 15 PPOs with the five largest HMOs controlling 36% of the market. Charlotte has 25 HMOs with North Carolina HMO membership up 40% in 1994. In South Carolina HMO membership grew 59% in 1994.³

In contrast to urban areas, managed care has not grown as rapidly in small cities and rural areas, even when located in regions where overall managed care penetration is high. However, this is not always true. For example, in New Hampshire 31 PPO networks (!) control 14% of the market.

The vast majority of physicians participate in some form of managed care contracting with 75% of physicians having one or more managed care contracts. Furthermore, physicians derive an average of 35% of their revenue through managed care contracts.

The highest growth rate in managed care participation has been led by internists, obstetricians and gynecologists, and hospital based physicians (anesthesiologists, radiologists, pathologists, and emergency medicine physicians). Typically, such physicians derive 40 to 50% of their revenue from managed care contracts compared to 41% for pediatricians and family practitioners. Physician participation in managed care plans also increases as the size of the practice grows. Younger physicians rely more heavily on managed care contracts than older physicians.

As pointed out by Ms. Beck, people other than physicians own and control managed care contracting. Insurance companies including Blue Cross and Blue Shield own 37.7% of HMOs and

50.1% of PPOs; national managed care companies own 16.8% of HMOs and 7.9% of PPOs; physicians, physician groups and Provider Health Organizations (PHOs) combined own only 7.5% of HMOs and 8.9% of PPOs. Moreover, physician ownership of these organizations has been steadily declining since the mid-1980s. In contrast, it's no surprise or secret that insurance company ownership and managed care companies (organized specifically for this purpose) are rapidly increasing their ownership and dominance of all managed care markets. Furthermore, our friends in the federal government's antitrust division of the Justice Department and the Internal Revenue Service (IRS) are using antitrust legislation and the tax laws in such a way as to club individual physicians, physician groups, and physician organized networks into submission to these cash flush corporate and insurance organizations. Paradoxically, this is precisely the opposite application for which such laws were intended when first conceived of by President Theodore Roosevelt. How ironic!

The number of large corporately owned HMOs, PPOs, and others is staggering. By 1992 there were at least 2,578 PPO networks in which physicians and other providers had virtually no influence or say in medical decision making and payment policies. There are somewhere between 300 and 1300 IPA networks which still appear to be owned by physician organizations. However, they usually contract with over 800 corporately owned HMOs. Finally, there are over 800 large multi-specialty group practices that also contract with HMOs and PPOs.

The results of the above combinations produce tremendously diminished physician autonomy both economically and medically. Utilization review, practice parameters, exclusive use of gate keeper physicians, restricted provider panels (including deselection of so-called high cost or poor quality physicians) and risk sharing arrangements including fee withholds, bonuses, and capitation work to guarantee that managed care networks will maintain strict and tight control over all physicians and other health care deliverers. It is galling to the medical profession to realize that optimal recovery guidelines for appropriate

lengths of hospital stay have been developed by Milliman and Robertson (an actuarial and consulting firm!) that are based upon statistical studies of the top 10% of patient outcomes. Thus, physicians are being demanded to perform to a standard not taken from the average case but from the absolute best cases where health care is delivered with a very mature infrastructure consisting of readily available home health care, rehabilitation, skilled nursing facilities, outpatient IV therapy and nursing homes. It is hard not to see that many of our colleagues are being "set up to fail," and thus the deselection process begins. Where are all of these savings going? Currently, the US spends 14% of the Gross National Product (GNP) on health care and while the rate of increase is slowing, the overall rate of increase continues to go up. From where I'm sitting, I personally don't find anyone's insurance premiums actually decreasing from year to year. Instead, this looks like a transfer of wealth from health care providers (physicians, hospitals, and others) to insurance companies and managed care companies. For example, the chief executive officer (CEO) of a large successful for-profit HMO earned almost 10 million dollars in salary, bonus, and stock options in 1993! The salad days are truly here if you're in the right place.

Don't get me wrong; perhaps these comments should have been submitted to Charles Bryan, MD, for inclusion in the editorial column of *The Journal* rather than in my trustee's report. Our country was founded on capitalist principles and I believe as strongly in these as the next person. What organized medicine and physicians as individuals must do is move to rapidly influence as much as possible and as positively as possible the changes underway in the current medical care revolution.

Influencing change will not be easy and it will take a personal and professional commitment from every single physician in our district five area to achieve a more desirable outcome for the medical profession as a whole. What can each of us do to help? More than ever physicians need to be involved in the direction, operation, and management of health care systems whether they

be your local hospital, or any other managed health care organization. Physicians understand quality medical care and can take the lead in the scientific assessment of quality standards and continue to champion the goals of proper and adequate patient care and in retaining the personal and humanitarian side of medicine. The need for expert physician providers and managers (you can now get an MD-MBA) is going to increase rapidly in the years to come. Many of you are in responsible positions in your communities and hospitals which will allow you to take the lead in this area. Help self-insured employers and business coalitions work out and choose health care options that will furnish them reasonable savings without compromising patient care. Your Physicians Care Network (PCN) and your local PHO can help you compete in this environment but only if you take the time and initiative to make them work. The focus is shifting to overall health and wellness of patients (read beneficiaries) rather than treating illness. Who better to know about health and wellness than physicians? Certainly not the self-proclaimed "experts" that appear on the television talk shows with their latest fad exercise or fad diet book. Promote your profession and your professionalism; emphasize patient and physician autonomy with choice; promote good medical science and research; encourage irrefutable medical ethics by insisting on safeguards of the rights of patients and physicians; help develop reasonable standards of clinical practice; reach out and build coalitions with other health care organizations and health care professionals including nurses, technologists, therapists and others (after all they are being hit with the same problems we are); advocate insurance portability and reasonable choices of health plans; pursue antitrust reform; help develop new ways and new products designed to enhance the availability and affordability of medical care for all citizens; and finally, maintain your membership in your county, state, and national AMA — after all, their voices insure that we will continue to be forcefully heard. And, oh yes, keep in touch with your politicians and political friends. Your opinions do mean something to them, even if

they don't always vote your way.

Don't despair and don't give up, great challenges and great opportunities lie ahead of us. Each of us can make a difference. Calculated financial decisions do not have to replace dedication, devotion, and outstanding health care.

Someone once said "The future ain't what it use to be!" The future can be ours and will be ours if we work to make it so.

Thank you for your support in the past two years. I am up for reelection this year and hope that you'll support me for another two years as your representative on the board from the Fifth Medical District

R. Duren Johnson, MD
Trustee, Fifth Medical District

REFERENCES

1. Beck, Joan. Doctor's Should Decide Health Care's Future. *Charleston Post and Courier*. Friday, Feb. 3, 1995; p. 17-A.
2. Seward, MD, P. John, et al. Report of the AMA Board of Trustees: Managed Care and the AMA's Private Sector Initiatives; B of T Report 31-I-94.
3. Jamieson, Sean. HMO Membership Up 40% in N.C. last year. *Charlotte Observer*, Feb. 23, 1995; p. D-1.

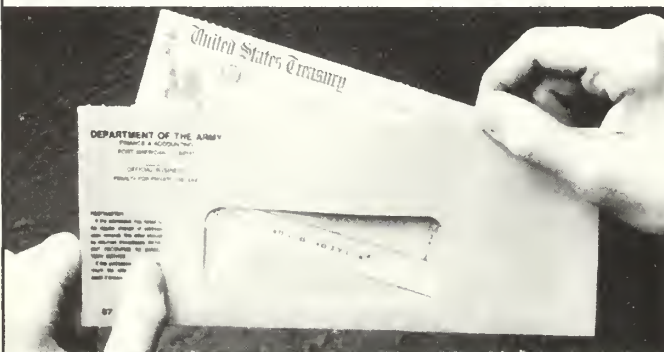
TRUSTEE, EIGHTH MEDICAL DISTRICT

The major factor influencing medical decisions should be what is best for the patient. Steps that guarantee enhancement of quality and appropriateness of care should be supported by all physicians. THINK ABOUT IT!

Dallas W. Lovelace, III, MD
Trustee, Eighth Medical District

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COMMITTEE REPORTS

THE MATERNAL, INFANT AND CHILD HEALTH COMMITTEE

The Maternal, Infant, and Child Health (MICH) Committee provides comments and recommendations to several state agencies responsible for monitoring and financing maternal, infant, and child health. Representatives from the South Carolina Health and Human Services Finance Commission (HHSFC), Department of Health and Environmental Control (DHEC), Governor's MICH Council, as well as the South Carolina Hospital Association (SCHA) not only attend our committee meetings, but also update the committee on issues ranging from teen pregnancy to neonatal CPT codes to the Palmetto Health Initiative. Highlights from our year include a substance-abuse screening follow-up, licensure of lay midwives, the South Carolina Medical Association (SCMA)/SCHA Very-Low-Birth-Weight (VLBW) Committee, and review of maternal deaths.

Last year, the MICH Committee developed a drug and alcohol screening for obstetricians and family practitioners responsible for maternal health to identify substance-abusing pregnant women. This year, the MICH Committee will conduct a follow-up survey to determine how many physicians are using the MICH Committee's screening and if not, what screening tool is used. This project is in response to an inquiry from the Governor's MICH Council, Substance Abuse Subcommittee.

The MICH Committee voted to take actions to rescind the licensure of lay midwives. In 1993, DHEC began licensing lay midwives. As a result, these non-nurse midwives are allowed to enroll with the HHSFC as a Medicaid provider and receive reimbursement for their services which is 65% of physicians' reimbursement. The MICH Committee felt strongly that this was a step backwards in improving the health of South Carolinians.

At the request of DHEC's Perinatal Regionalization Work Group, the SCMA and SCHA are developing a Joint VLBW Committee. The Joint VLBW Committee would conduct a voluntary

review process for hospitals whose percentage of 500 to 1,499 gram live births is statistically significantly higher than other hospitals of the same level or increasing over a period of time. The hospital will choose three reviewers from a list of physicians. Each MICH Committee member will be listed as a potential reviewer.

The MICH Committee continues to review all maternal deaths in South Carolina. Conducted in executive session, these reviews are strictly confidential.

Ralph F. Principe, MD, Co-Chairman

Dilip M. Purohit, MD, Co-Chairman

THE MEDIATION COMMITTEE

The Mediation Committee continued to receive a relatively low number of complaints between May, 1994 and March, 1995. The committee notes that an increasing number of complaints are now being processed by the grievance committees of various county medical societies.

Eighteen complaints were received by the committee between April, 1994 and March, 1995. Of this number, eight were referred to the appropriate local medical society where the complaints were handled to conclusion. The remainder of the complaints were handled by South Carolina Medical Association (SCMA) staff.

I wish to thank the members and SCMA staff for their support this year.

Albert G. LeRoy, Jr., MD

Chairman

THE MEDICAL ASPECTS OF SPORTS COMMITTEE

The Medical Aspects of Sports Committee met quarterly in 1994. The safety of athletes of all ages has been the primary concern of the committee. A resolution to the 1994 South Carolina Medical Association (SCMA) House of Delegates addressed requiring an individual certified in cardio-pulmonary resuscitation (CPR) be present at all sports activities, whether practice or competition, sponsored by any recognized or other sponsoring organization in the state of South Carolina. The committee is working with

the South Carolina High School League to investigate and institute this safety provision.

The Medical Aspects of Sports Committee has been approved as an official affiliate of the South Carolina Governor's Council on Physical Fitness. This representation allows the committee to be a vital part of the effort to inform and educate committees concerning physical activity and healthy lifestyles.

The Annual Medical Aspects of Sports Seminar was held on April 30, 1994 in conjunction with the Annual Meeting of the SCMA. The seminar's topic was "High School Athletic Issues" comprised of panel discussions addressing preparticipation physicals and blood borne pathogens. The program was well received by those in attendance. The 1995 Annual Meeting program will be a panel discussion addressing "What's New" and "Returning A Sick or Injured Athlete Back to Participation."

The role and purpose of this committee has been to continue to collect and develop pertinent information regarding the prevention and treatment of athletic injuries in South Carolina and disseminate this information to those responsible for administering athletic programs in the state.

Robert M. Peele, MD
Chairman

THE MEDICAL ETHICS COMMITTEE

The South Carolina Medical Association (SCMA) Medical Ethics Committee continues to be extremely active as the health system reform movement raises more and more questions about medical ethics and the role of the physician in the health care system. The committee continues to receive welcome support from our PhD consultants. Douglas MacDonald, PhD, from Furman University; Stuart Sprague, PhD, from Anderson College; Bert Keller, STM, from MUSC; Mary Faith Marshall, PhD, from MUSC, and James A. Keller, PhD, from Wofford College all provide tireless effort without compensation to our committee.

The committee devoted the summer and fall of 1993 to developing a position statement concerning the definition of and withholding of inef-

fective treatment in hospital settings. The committee also developed a statement and suggested an implementation policy for guidelines relating to Do Not Resuscitate Orders. These statements were presented to the SCMA Board of Trustees for approval in November, 1993. The SCMA board adopted both statements as SCMA policy and moved to form a committee with the South Carolina Hospital Association to explore statewide implementation of the policies at all hospitals. The joint committee began meeting in the fall of 1994 and approved a final statement which was published in the February, 1995 issue of *The Journal*.

The committee held its annual retreat in February, 1995. We were honored to have as our guest David Orentlicher, MD, JD, who serves as staff support to the Council on Ethical and Judicial Affairs of the American Medical Association. The committee spent three days discussing the ethical, legal, and religious issues raised by physician-assisted suicide. The work from the retreat will serve as the basis for the committee's continuation of discussion on this sensitive and complicated subject in 1995.

The committee was honored to produce a special symposium issue of *The Journal* in February, 1995 devoted solely to the subject of medical ethics. The issue contains many of the products of our work over the last two years.

In the future, the committee will strive to be a resource for hospitals and local medical societies desiring to establish or enhance their ethics committees. We will also strive to continue to provide practical advice to members of the SCMA about ethical issues in medicine. Our goal is to provide South Carolina physicians with ethical information that can be understood and applied in the daily practice of medicine. The committee appreciates the support it has received from the SCMA Board of Trustees and the input it has received from various members of the SCMA who have raised suggestions for future discussions.

Finally, we note with sadness the retirement of one of the committee's members, J. Richard Sosnowski, MD, and the transfer of Debra Perina, MD, to North Carolina.

Dr. Sosnowski's wisdom and curiosity about the nature of healing and the human spirit will be deeply missed, as well as the presence of his wife, Elizabeth, at our annual retreat. We wish them both well as Dr. Sosnowski prepares to spend all of his time with his true passion, training young physicians in obstetrics and gynecology.

Dr. Perina's important insights as an emergency room (ER) physician into many of the committee's discussions about death and dying will also be missed. Dr. Perina was a dedicated member of the committee who saw the need for our work on a daily basis in the ER. We wish her well in her new position on the faculty of the University of North Carolina School of Medicine.

Charles R. Duncan, Jr., MD
Chairman

THE MEMORIAL COMMITTEE

During this time of year we convene here in Charleston for our Annual Meeting. It's a time of education, legislation and a time to renew old acquaintances. It is also a time of paying our respects to those who are no longer in our midst. During the last year we have lost several physicians who have made contributions to their families, communities and to the medical field. It seems only right that we, the members of the South Carolina Medical Association, take a moment from these proceedings to recognize those physicians and to pay honor to their memories and to their families.

After the following names have been read, we will stand for a moment of silence, out of respect for their memories: Frederic W. Brown, MD, Chester; George H. Bunch, Jr., MD, Columbia; Edward M. Butler, MD, Sumter; Oscar E. Glover, III, MD, Orangeburg; W. Burns Jones, MD, Beaufort; Lawrence V. Jowers, MD, Columbia; Malcolm L. Marion, Jr., MD, Chester; Francis C. McLane, MD, Ninety Six; W. H. Thames, MD, Greenville; James G. Tippins, Jr., MD, Myrtle Beach; and William O. Whetsell, Sr., MD, Orangeburg.

Samuel R. Stone, MD
Chairman

THE OCCUPATIONAL MEDICINE COMMITTEE

The South Carolina Medical Association (SCMA) Committee on Occupational Medicine held several meetings during 1994. The committee continued its evaluation of the South Carolina Workers' Compensation Commission (SCWCC) fee schedule.

The original fees for the SCWCC fee schedule were based on the California Relative Value Schedule (which is now obsolete). As new codes were added and revisions were made annually in the CPT-4 books, the SCWCC would bring the new codes and revisions before this committee for their assistance in setting new fees and guidelines. This was a very time consuming process. Each year CPT codes are added, deleted and changed. The SCWCC felt that there were many disparities in reimbursements and that there needed to be a more straight forward, timely and systematic means of updating the fee schedule. An advisory committee was formed through the SCWCC which included representatives from insurance companies, employers, medical review companies and medical providers including three physicians from this committee. As a result of these meetings, the advisory committee recommended that the SCWCC adopt the Health Care Financing Administration's (HCFA) resource based relative value scale (RBRVS) with a conversion factor of \$52.00.

In April, 1993, the SCMA House of Delegates voted to support the use of the RBRVS to create an equitable fee schedule as long as it was not used as a cost containment device.

Based on the House of Delegates decision, the SCMA Board of Trustees wrote a letter in support of the SCWCC's move to the RBRVS recommending a dual conversion factor of \$52.00 for primary care and \$60.00 for surgery. The SCWCC very adamantly advised the SCMA that dual conversion factors were not feasible. The SCWCC advised that a \$52.00 conversion factor would increase fee payments by 5.1% overall. Surgery fees would increase 4.1% overall, and medical fees would increase 5.7% overall.

In support of the House of Delegates decision, in May, 1994, the SCMA Board of Trustees

wrote a letter continuing to support implementation of a fee schedule based on the RBRVS methodology, with a fair conversion factor which would provide some additional reimbursement for the years since 1989 in which physicians had received no increase in Workers' Compensation fees. In lieu of this, the Board of Trustees requested consideration of a \$1.00 increase in the current conversion factor to be effective as soon as possible. The \$1.00 increase was rejected outright by the SCWCC.

In October, 1994, SCWCC adopted the RBRVS with a conversion factor of \$52.00. The new fee schedule will be in effect in 1995. Fees which still seem inappropriate will be brought before the committee on an individual basis. The Health Care Financing Administration (HCFA) 1500 claim form was also adopted for use.

The role of the SCMA Committee on Occupational Medicine was reviewed. The committee should be an arbitrating force for peer review, fee disputes, managed care, education and training and a resource for the SC Workers' Compensation Commission and the SCMA.

Discussions are being held regarding the way that disability ratings are being done and the need to develop specific legislative guidelines for impairment ratings. This discussion continues into 1995.

The committee welcomed new members in 1994. They are Jeffrey C. Williams, MD, Anesthesia; Andrew E. Floren, MD, Occupational Medicine and Jay Hammett, Sr., MD, General Practice/Occupational Medicine.

Physicians fees which seemed inappropriate to the Medical Department of the Industrial Commission were reviewed at each meeting and recommendations were made to the commission on an individual basis.

The SCMA staff continues to collect a list of physicians willing to treat Workers' Compensation patients.

The SCWCC held their 16th Annual Workers' Compensation Medical Seminar, March 10 and 12, 1995, at the Mills House, Charleston, South Carolina. I hope all physicians were able to attend this meeting.

Members of the Occupational Medicine Com-

mittee and the SCWCC are always available to participate in panel discussions during the SCMA Annual Meeting or to speak at county medical society meetings.

In summary, 1994 was a very busy year for the committee in fulfilling its role as liaison between the SCMA and the SCWCC, as well as a resource group to the commission as it attempts to fairly administer the Workers' Compensation Law of the state of South Carolina.

I would like to thank all committee members, SCMA staff and SCWCC staff for their hard work this past year.

Marion F. McFarland, III, MD
Chairman

THE PHYSICIANS' ADVOCACY AND ASSISTANCE COMMITTEE

This report is written to all of those who are interested in what our committee does and how it interacts with physicians who are impaired. The committee has quarterly meetings for interviewing physicians who are under contract and insuring that they continue to comply with their contractual arrangements. Five regional teams throughout the state report on their activities.

One of the highlights of this year was our annual workshop entitled "Protecting Your Medical Practice." This was well received, and it was informative and helpful in educating physicians on the present state laws regarding prescription drug dispensing.

One of our meetings was attended by Henry D. Foster, Jr., Executive Director of the State Board of Medical Examiners. He informed us of his desire to have a closer relationship, and detailed exactly how he expected us to advocate for our physicians under contracts. Mr. Foster was very well received, and our relationship continues to grow in a healthy way.

Our committee is thankful for the support of the South Carolina Medical Association (SCMA). We wish to thank the SCMA Board of Trustees, committee members, the SCMA Alliance, and the SCMA staff for their support.

Theodore A. Watson, MD
Chairman

THE PRIMARY CARE/MEDICAID AND INDIGENT CARE COMMITTEE

Due to the changing health care environment in South Carolina and the handling of the Medicaid waiver by the Board of Trustees, the committee has not met in the past year.

Since our meeting last year, Governor Campbell applied for a 1115 waiver, allowing South Carolina to expand Medicaid eligibility to 100% of the federal poverty level and enroll Medicaid recipients in managed care health plans. The Health Care Financing Administration (HCFA) approved the framework of the proposed plan but will not grant full approval until the Finance Commission provides more specific details such as the capitated rates, quality assurance, and budget neutrality.

HCFA is not the only obstacle impeding immediate implementation of the Palmetto Health Initiative. The new governor and General Assembly may have their own ideas concerning Medicaid reform and, more specifically, the Medicaid budget.

The Primary Care, Medicaid, and Indigent Care Committee could play an important role in educating our fellow South Carolina Medical Association (SCMA) members on the Palmetto Health Initiative and providing physician feedback to the Finance Commission. However, until we have more details concerning the fate of the Palmetto Health Initiative, our efforts could be futile.

The committee plans to meet in the spring when we will have more information about the Pal

Trent Cannon, MD
Chairman

THE PUBLIC RELATIONS AND COMMUNICATIONS COMMITTEE

Concentration on member communications was a major undertaking this year in terms of publications and other services. Among the publications available to members this year were the SC Physicians' Guide to Managed Care Contracts, brochures highlighting the benefits of membership in the South Carolina Medical Association (SCMA), staff directory and rolodex cards for members with numbers and staff frequently called. For those members who sought a better

understanding of the Palmetto Health Initiative (PHI), a 1-800 hotline was installed, allowing members to phone in questions with responses mailed to them within five working days. The hotline was promoted through the "SCMA Newsletter," one of Dr. Burton's President's Pages and flyers in the membership mailing. Questions of particular interest to the overall membership were published in the newsletter. Additionally, information concerning public health issues such as immunization were addressed in the newsletter. Staff is working with the Department of Health and Environmental Control (DHEC) - Preventive Health Services on developing a quarterly insert for *The Journal* dedicated to public health issues. A radio advertisement hit the airwaves in September advocating patient choice and preserving the physician-patient relationship that triggered a positive response among the membership.

The South Carolina Institute for Medical Education and Research (SCIMER) received press coverage this year for being awarded a grant by the Robert Wood Johnson Foundation. The grant - REACH OUT: Physicians' Initiative to Expand Care to Underserved Americans - is a national effort to mobilize physicians to enhance access to care for underserved populations. SCIMER's program, PARTNERSHIPS FOR CHILDREN (PFC), will expand upon three existing public-private partnerships sponsored by DHEC entitled Child Health Initiatives. PFC will institute partnerships between public health departments and private physicians in each of South Carolina's 13 health districts in an effort to increase access to medical and preventive services while securing medical homes for Medicaid pediatric patients.

Dr. Burton was active in the public speaking arena. He presented speeches to various health care, civic, and service groups, as well as taking part in media interviews. Two highlights during the year include accompanying Dr. Randolph D. Smoak, AMA Trustee, on a media tour of Columbia, Greenville and Spartanburg, where the two met with editorial boards and health care reporters. In addition, Dr. Burton served as a panelist with Dr. P. John Seward, AMA Chairman

of the Board, to discuss health system reform during a taping of PBS' Firing Line moderated by William F. Buckley, Jr.

Other activities during the year include assisting DHEC – Emergency Preparedness Division in surveying physicians concerning their willingness to participate in formulating a plan of action that will assure the provision of medical care during disaster periods. Moreover, staff has interacted with Physicians Care Network (PCN) in developing and placing a newspaper advertisement announcing PCN to the lowcountry area as well as keeping the membership informed about PCN's activities via updates in the "SCMA Newsletter." Staff has designed and assisted with various marketing tools for both Members' Insurance Trust (MIT) and SCMA Financial Services, Inc. "Health Care Volunteer News & Views" is published quarterly, featuring articles of interest to the free and reduced-fee clinics throughout the state. This publication is mailed to these clinics as well as to our legislators. Staff also represents the SCMA on the following external committees, providing assistance with public awareness/education and media relations: Childhood Injury Prevention Action Council, Christian Action Council, Commu-n-I-Care, Governor's Council on Advance Directives, Governor's Immunization Awareness Committee, South Carolina Coalition on Adolescent Pregnancy Prevention and South Carolina SAFE KIDS.

The Public Relations and Communications Committee looks forward to continuing its efforts to educate both the membership and the public on important issues and to strengthen the image of physicians in the community.

Edward W. Catalano, MD
Chairman

THE SCMA/JUA PHYSICIANS' RISK MANAGEMENT COMMITTEE

Dr. Euta Colvin, the long-term chair of our committee, last year requested that he not be reappointed as the chairman of this committee. He continues to serve on the committee, however, and we are grateful for his continuing contributions in this area.

I was appointed to chair this committee last summer and hope to continue the committee's involvement in the two areas in which we traditionally have been able to make a difference. We have been involved both in the support of our colleagues who have been sued for malpractice, and also in attempting to educate our fellow South Carolina physicians in ways to avoid becoming involved in the malpractice arena in the first place. We now host a spring and fall risk management conference for new physicians entering the state to begin their practice. The JUA provides a financial incentive to attend which has been well received. This conference continues to be very popular. It is held at the SCMA Headquarters as a way of exposing the new physicians to organized medicine in this state.

Dr. Bart Barone and I serve on both this committee and the board of the Joint Underwriters Association (JUA). This has enabled our committee to maintain good communication with the JUA board. We continue to be grateful for the assistance which we most generously receive from Mr. Cal Stewart, the JUA Manager. This year, Mr. Stewart has made available to us data relating to JUA closed cases. We hope to make use of this data to strengthen our prophylactic risk management effort. They can take a lot of the credit for this wonderful accomplishment.

Finally, I would like to recognize the exemplary contribution of Ms. Joy Drennen for her devoted service to the committee. We greatly appreciate her support.

John R. Hunt, MD
Chairman

OTHER REPORTS

REPORTS OF THE BOARD OF TRUSTEES

SUBJECT: Direct Access to Specialists INTRODUCTION

Resolution Number F-4, "DIRECT ACCESS TO DERMATOLOGICAL CARE," was referred to the Board of Trustees at the 1994 Annual Meeting. This resolution calls for the South Carolina Medical Association to adopt as policy the following:

"RESOLVED: That the South Carolina Medical Association support the concept of direct patient access to dermatologists and all other specialists who can demonstrate the quality and cost-effectiveness of such care."

In preparing this report the Board of Trustees met with a representative of the sponsors of this resolution at the September, 1994, Board Retreat and at that time the discussion was tabled until after the American Medical Association (AMA) Interim meeting. Staff also made inquiries of a number of other state associations and a request was transmitted over AMANET seeking guidance from any medical organization that had taken up this issue.

At the 1994 AMA Interim meeting, direct access to specialty care was not discussed. This leads the board to believe that the position adopted by the AMA at the 1994 Annual Meeting satisfied those who were seeking a position from the AMA. The SCMA Board of Trustees recommends that a position consistent with that of the AMA be adopted.

RECOMMENDATIONS

The Board of Trustees recommends that the following statements be adopted and that the remainder of this report be filed:

1. That the SCMA strongly encourage primary care and other medical specialty organizations to collaborate in developing guidelines to delineate the clinical circumstances under which treatment by primary care physicians, referral for other specialist care, and direct patient self-referral to other specialists are appropriate and cost effective; and,
2. That the SCMA encourage the medical specialty organizations that develop such guidelines to document their impact on the quality, accessibility and cost-effectiveness of care; and,
3. That the SCMA urge all health plans that control access to services through a primary care case manager to cover direct access to and services by a specialist other than the case manager without financial penalty when that access is in conformance with such guidelines.

REFERENCES

1. AMA Council on Medical Services Report 1 - A94: Access to Specialty Care.
2. AMA Council on Medical Services Report I-93-5: Patient Access to Specialty Care in Managed Care Systems.

S. Nelson Weston, MD

Chairman, SCMA Board of Trustees

SUBJECT: Any Willing Provider Legislation INTRODUCTION

Resolution Number D-5, "ANY WILLING PROVIDER LEGISLATION" was referred to the Board of Trustees at the 1994 Annual Meeting. This resolution calls for the South Carolina Medical Association to adopt as policy the following resolves:

"That the South Carolina Medical Association go on record as supporting the patient's right to choose his or her provider and the provider's right to participate in a managed care environment, and that introduction of legislation be encouraged in the 1995 General Assembly to guarantee these rights."

The Board of Trustees directed staff to draft legislation to be introduced in the 1995 Legislature and the draft was approved at the January Board of Trustees meeting. The board, in approving the draft bill, felt that it was important for the House of Delegates to review and approve the bill prior to introduction and a copy of the draft bill (The South Carolina Managed Care Improvement Act of 1995) is included in this report as Attachment A.

A second issue to be considered is a bill (S.385)

introduced in the Senate which gives the insured the right to assign his or her health insurance benefits to the provider of his or her choice. We are calling this bill the "Patient Choice Bill." The language contained in this bill is included in this report as Attachment B.

The board is of the opinion that it is of supreme importance that the medical profession in South Carolina take a unified stand on this issue and move forward to enact the legislation the House adopts.

S. Nelson Weston, MD

Chairman, SCMA Board of Trustees

ATTACHMENT A

A BILL

The South Carolina Managed Care Improvement Act of 1995

Section 1. Definitions

As used in this act:

a) "health care provider" or "provider" means any person, corporation, partnership, joint venture, network, cooperative arrangement, or any group of people or entities who are licensed or certified to practice the healing arts pursuant to any chapter of Title 40 of the S.C. Code of Laws, or any chapter of title 44 of the S.C. Code of Laws.

b) "managed care organization" or "organization" means any person or group of people, corporation, partnership, joint venture, cooperative arrangement, insurance company, insurance company licensee, or any other group or entity whose purpose is to design and market health care services in South Carolina, whether as an insured product or otherwise, utilizing principles of utilization review, quality assurance, rationing, or any other mechanism as an integral part of its business to control health care costs.

c) "managed care provider contract" means any written agreement between a health care provider and a managed care organization wherein the health care provider agrees to provide services of any description to the managed care organi-

zation or entities.

d) "participating provider" means a health care provider who has been accepted by and has signed a managed care provider contract with a managed care organization.

e) "non-participating provider" means a health care provider who has not signed a managed care provider contract with the managed care organization.

Section 2. Every citizen of this state shall have the right to receive health care from the provider of their choice. Citizens enrolled in managed care plans have the right to receive treatment from non-participating providers. If an enrollee in a managed care plan elects to receive health care services from a non-participating provider, the managed care organization must reimburse the non-participating provider on the same terms as it reimburses similar participating providers. However, in order to assure viability of managed care systems in this state and to ensure cost control the managed care organization may reduce the amount of reimbursement paid the non-participating provider by as much as 15% of the amount paid to a participating provider. Any non-participating provider who provides services in this circumstance may collect outstanding balances directly from the patient after payment is made by a third party and is hereby deemed to be subject to the same utilization review, pre-certification procedures, and quality assurance criteria as are participating providers.

Section 3. Any managed care organization doing business in South Carolina must allow any health care provider to apply to the managed care organization to be accepted as a participating provider. This universal right shall apply only to the application process. A managed care organization shall have the right to deny acceptance of the provider into the managed care organization as a participating provider on the following bases:

a) the provider is not properly licensed, regis-

tered, or certified in this state

b) the provider's application and/or investigation of the matters contained therein indicate the practice history of the provider is not suited to the managed care organization

c) the managed care organization has a sufficient number of providers in the applicant's specialty area or geographic area to meet its optimum demand for these services

d) the services offered by the provider are not utilized by the managed care organization

Section 4. Any managed care organization doing business in South Carolina must publish and provide to applicants a list of criteria serving as a condition precedent to participation in the system which at a minimum outlines:

a) the geographic area in which the organization intends to provide services

b) the number of people in the geographic area likely to need medical services

c) the number of medical doctors, by specialty, needed to provide appropriate services at an optimum level for the business purposes of the organization

d) the number of hospitals and outpatient facilities needed to provide appropriate services at an optimum level for the business purposes of the organization

e) the types of non-medical doctor providers who will be utilized by the organization

f) a general description of the types of entities to which the organization intends to market its services to

Section 5. A managed care organization doing business in South Carolina may not terminate a participating provider from the organization without first notifying the provider, in writing,

of the grounds for termination. The participating provider so notified shall have ten days to request review of the grounds for termination by the managed care organization. If such review is requested, the managed care organization shall review the termination offering the following minimum due process:

A. If the basis for termination is alleged improper utilization of services, and it is the first occurrence of such an allegation, the managed care organization must inform the provider of the extent and nature of the alleged improper utilization and afford the provider the opportunity to alter his or her practice pattern in a manner suitable to the managed care organization. This review may be conducted administratively within the rules and regulations of the managed care organization.

B. In all other circumstances, including a second allegation of improper utilization:

1) the provider must be notified at least 30 days in advance of the date, time, and location of the hearing, and of the provider's right to have counsel present.

2) the managed care organization has the right to have counsel present.

3) a hearing panel of three providers, all of whom, when possible, must be in the same specialty area or medical enterprise as the provider will hear the matter. A hearing officer, mutually agreed to by the parties, shall preside over the hearing. No person sitting as a hearing officer can be in economic competition with the provider or be employed by an entity in economic competition with the provider.

4) both parties have the right to conduct reasonable discovery, through subpoena, deposition, or otherwise, present evidence and conduct cross-examination.

5) the managed care organization shall provide, and pay for, a means of recording the proceed-

ings which will allow a review of the record at a subsequent time.

6) the hearing panel must reach a decision to uphold or reverse the decision to terminate the provider within 10 days. If desired, the non-prevailing party has the right to request the board of directors of the managed care organization to review the record of and the hearing panel's decision. The board of directors may sustain or reverse the decision of the hearing panel. The decision of the board of directors is final.

7) nothing contained in this chapter shall prohibit either party from pursuing other remedies that may be available to them.

Section 6. Any clause existing in any managed care contract, whether executed before or after the effective date of this legislation, allowing for termination of a provider without cause, is hereby declared null and void as a matter of public policy.

Section 7. Any clause existing in any managed care contract, whether executed before or after the effective date of this legislation, containing any language, express or implied, which operates to or may operate to have the legal liability of the managed care organization, its processes and procedures, and acts and/or omissions, including those of its agents, committees, assigns, or directors, indemnified by the participating providers is hereby declared null and void as a matter of public policy.

Section 8. There is hereby created the South Carolina Managed Care Uniform Credentialing Council, made up of the chief executive officers from the SC Managed Care Association, the SC Hospital Association, and the SC Medical Association, all appointed by the governor. The Council will design a uniform managed care credentialing application to be used by all managed care organizations doing business in this state. The council shall make a report to the Health Care Planning and Oversight Committee no later than April 1, 1995.

ATTACHMENT B

S.384 as introduced in the Senate reads as follows:

"SECTION 1. The 1976 Code is amended by adding:

Section 38-71-270. Nothing in this title may be construed to limit an insurer, health maintenance organization, preferred provider organization, health care service corporation, or other third party payor from determining the scope of its benefits or services or any other terms of its group or individual insured, or both, subscriber or enrollee contracts nor from negotiating contracts with licensed providers on reimbursement rates or any lawful provisions, except that the contract providing coverage to an insured may not exclude the right of assignment of benefits to a provider at the same benefit rate as paid to a contract provider.

REPORT OF THE CHIEF EXECUTIVE OFFICER

It is my pleasure to report to the House of Delegates on the activities of the South Carolina Medical Association (SCMA) and its subsidiaries.

As in the past I have had the opportunity to accompany the president and other officers to county medical society meetings. We welcome the opportunity to meet with you and discuss your concerns and the activities of the SCMA. I hope that those societies which we were able to visit found these visits informative. I would also encourage component societies, county or specialty, to invite representatives of the SCMA to your meetings. The opportunity to share information and to hear your views and concerns is important to the SCMA.

The 1994 elections have had a profound effect on the activities of the SCMA. Prior to November 8, 1994, many man hours were spent following the activities of government at the national and state level as health care reform proposals were introduced, studied and modified by a variety of committees. Today the private sector is

moving very rapidly to reform health care delivery and governments no longer mention health care as a major problem. Insurance company mandates, not legislative action, are driving health care reform and, for the most part, the average citizen is unaware of the consequences of this change. In reaction to the payor mandates, the private sector is responding with hospitals forming regional networks to compete with other hospital networks, large multispecialty groups forming to gain economic and negotiating power, and our own Physicians Care Network operating a statewide managed care program.

This new environment is developing day by day with philosophical changes that are foreign to the ways of the past. Government downsizing, tax reform, budget cuts, moving to a cabinet form of government and many other activities are changing the way the legislature and the state agencies do business. The SCMA's interaction with this new government is changing as well. I would refer you to the report of the Legislative Activities Committee for a more detailed analysis of the bills we are following. I do not want to give the impression that we no longer need to be vigilant but only that we are in a state of flux.

The fiscal affairs of the association and subsidiaries remain healthy as does membership in the association. I refer you to the reports of the treasurer and the chairmen of the subsidiary boards for details. I would like to take this opportunity to highlight a few points. The South Carolina Institute for Medical Education and Research (SCIMER) is providing a tremendous opportunity for physicians to participate in the Section 170 Program. Representatives of SCIMER have a booth in the exhibit area and I recommend you visit and learn about the pension and tax benefits of this program. SCMA Financial Services, Inc., our insurance agency, is now one year old and providing SCMA members with sound advice about their insurance needs. The Physicians Care Network is operational statewide and is providing managed care services to self-insured employers in the state. We reported last year that the SCMA had an increase in membership of 500 members and that trend continues. We have not had a dues increase since 1989

and we do not anticipate one in the foreseeable future.

A new activity the SCMA has undertaken this year was to apply for and be awarded a grant from the Robert Wood Johnson Foundation to develop public/private partnerships to provide health care through PARTNERSHIP FOR CHILDREN. The SCMA has subcontracted with the Department of Health and Environmental Control (DHEC), and through the joint efforts of the two organizations a network of partnerships is being developed throughout the state.

Last year I reported to you that the SCMA was involved in discussions with technology companies to determine how emerging technologies can be applied to medical practice. I am happy to report that we are working closely with Bell-South to make technology available to physicians. We hope to announce in the very near future the results of our efforts and make an enhanced data communication system available to physicians. We are also investigating other areas of technology to enhance communication between the SCMA and the membership. Fax broadcasting that will provide the membership with up-to-the-minute communications and Internet are two of the most promising. The staff of the SCMA is utilizing computer technology to the point now that every employee has access to the computer via terminals in their offices, as well as from their homes if they have a home computer. The use of computers began in the SCMA in the mid to late '70s and has evolved from one of the first personal computers available on the market to the highly sophisticated system we operate today. Technology has played a significant role in keeping administrative costs down in the SCMA and we hope to assist you in taking advantage of these same technologies, not only for the administration of your office, but in the practice of your profession as well.

I have been an employee of the SCMA for over 20 years and I can state without reservation that the organization is the strongest it has ever been. We have the largest membership ever and represent the highest percentage of South Carolina physicians this year than in the past 40 years. The SCMA is financially strong and employs a staff

of highly competent and dedicated individuals who work very hard to serve the physicians of South Carolina. The greatest strength of the SCMA is the leadership provided by a hard-working and dedicated Board of Trustees.

At the national level the SCMA is providing leadership through Randy Smoak, MD, serving on the AMA Board of Trustees; Walter Roberts, MD, serving on the Board of OSMAP; Ken DeHart, MD, serving on the CPT Editorial Board; Dina Grice, MD, serving on the AMA Advisory Committee on Women in Medicine; Carol Nichols, MD, serving on the AMA Federation Study Committee; and my service on the American Association of Medical Society Executives Advisory Committee to AMA EVP James Todd, MD.

Finally, let me take this opportunity to thank you on behalf of the SCMA staff and myself for your support over the past year.

William F. Mahon

Chief Executive Officer

REPORT OF THE EDITOR OF THE JOURNAL

We might remember 1994 as the "year of the symposium," since seven of the 12 issues of *The Journal* were given to special topics. We are deeply indebted to the guest editors. We believe such issues make our journal competitive with national and regional periodicals as a means of keeping physicians informed about state-of-the-art medicine. We further believe that such issues provide an ideal forum for physicians throughout South Carolina to cooperate toward common goals.

No fewer than 25 articles published by physicians in private practice during 1993 and 1994 were eligible for this year's Roe award. This is gratifying, for our editorial policy has been to honor the original purpose of *The Journal*: To provide a place for practicing physicians to publish their original observations. We continue to welcome guest editorials and letters-to-the-editor. To that end, we believe that it is appropriate to feature a guest editorial by a physician formerly in private practice (now retired because of the illness described in his poignant paper) in this

year's annual meeting issue.

I remain indebted to Elizabeth Y. (Betty) Newsum of the Waring Historical Library for the excellent covers, which make our journal a running showcase for South Carolina's medical heritage. And I also remain indebted to Joy Drennen, whose work continues to amaze me. Despite the dramatic decline in national advertising in recent years, the 1993-1994 budget year ended with *The Journal* being only \$51.28 under budget in revenues. This was due to our staff's efforts to generate local advertising revenues. And we are, of course, indebted to the advertisers.

I thank the Board of Trustees and the SCMA membership for the privilege of serving as editor.

Charles S. Bryan, MD

Editor, *The Journal*

MEMBERS' INSURANCE TRUST REPORT

The SCMA Members' Insurance Trust (MIT) completed last fiscal year with a surplus of \$2,424,657. The total revenues collected for the year ending June 30, 1994, were \$9,708,645, and claims paid plus expenses amounted to \$7,283,988.

The MIT Board voted not to raise premiums in March of 1994 and to continue to evaluate the financial picture to determine if an increase would be necessary. The rate structure is currently being studied by actuaries and the MIT Board will act according to their recommendations. The MIT is fiscally sound with reserves for incurred but not reported claims of \$1,825,000, and unassigned reserves of \$4,226,773.

A financial audit of the MIT was conducted by Elliott, Davis and Company and a copy of the audit is attached to this report for your review.

On August 15, 1994, the MIT initiated a managed care program by contracting with Physicians Care Network. To date the program has operated very smoothly and we anticipate savings at the end of the first year under the network.

The MIT continues to offer the advantages to physicians of guaranteed acceptance into the plan for SCMA members, coverage for your spouse if you predecease, and a plan totally operated and

financed by the SCMA. The plan is in its thirteenth year of operation.

A special thanks to the MIT Board and the staff of the SCMA for their hard work this past year. On a personal note, my term will expire at this Annual Meeting and I wish to thank the SCMA for providing me the opportunity to serve on the board of the MIT. The support provided to me personally by my fellow board members and the staff made my service very rewarding. I would encourage all SCMA members to consider the MIT for your health insurance needs. It is responsive to the needs of physicians in a way no insurance company can match.

Daniel W. Brake, MD
President

REPORT OF SCMA FINANCIAL SERVICES, INC.

It is my privilege to make this, the first annual report of SCMA Financial Services, Inc., to the House of Delegates. The original purpose of SCMA Financial Services, Inc. was to establish a wholly owned subsidiary of the South Carolina Medical Association (SCMA) which could handle the various insurance needs of the SCMA and collect the commissions which were being paid to insurance agencies and brokers around the state. Once we were in the business we found that there were many facets of insurance of which we had been unaware and that there was a definite advantage to employing agents who would look out for our best interests.

It became readily apparent that a similar service would be of immense value to the membership and thus SCMA Financial Services, Inc. has expanded to provide trained agents to consult with the membership and provide proposals from high quality companies at competitive prices. To date we are providing life, disability, health, and professional liability policies to the membership at the most competitive prices we can find.

Please visit our booth in the exhibit area and meet our agents.

Edward W. Catalano, MD
Chairman

REPORT OF THE PHYSICIANS CARE NETWORK BOARD OF DIRECTORS

I am pleased to provide the House of Delegates with information regarding the current status of the Physicians Care Network (PCN).

The PCN was formed early in 1993 in order to create a statewide economic unit of physicians who would work directly with employers to manage the cost and quality of health care. Many other state medical associations are now forming similar networks.

Our marketing efforts have confirmed that a large number of employers in South Carolina are interested in the Physicians Care Network, and we have been successful in being a finalist in many bids. The South Carolina Medical Association's (SCMA's) Members' Insurance Trust has implemented the Physicians Care Network and has experienced significant savings from PCN's negotiated rates with hospitals and ancillary service providers.

Other PCN clients are: Fennell Container Company, Inc., the largest independent waste hauler in South Carolina, and Employee Resource Management Company, the company chosen as the SC Emerging Entrepreneur of the Year for 1994.

Our network currently has over 2700 physician members as well as podiatrists and oral surgeons. Thirty-seven (37) hospitals have signed contracts with the network. PCN has also signed contracts with numerous reference laboratories, home health providers, ambulatory surgicenters, and other ancillary providers.

We have come a long way in a short period of time. We need your support in order to assure the continued success of the PCN. Specifically, we ask each SCMA member to:

- join the Physicians Care Network and encourage your colleagues to join;
- invite a PCN representative to your county or specialty society meeting;
- check whether your hospital is a member of the PCN and, if not, ask your hospital administrator to sign a PCN contract;
- provide the names of business contacts to either Barbara Whittaker, Senior Vice President, or George O' Laughlin, Marketing Director.

The success of PCN depends on the commit-

ment you, as physicians, are willing to make. Thank you for your support.

Daniel W. Brake, MD
Chairman

REPORT OF THE SOUTH CAROLINA INSTITUTE FOR MEDICAL EDUCATION AND RESEARCH (SCIMER)

The South Carolina Institute for Medical Education and Research (SCIMER) will award 21 scholarship grants at the 1995 South Carolina Medical Association (SCMA) Annual Meeting. Fourteen will be awarded jointly with the South Carolina Medical Association Alliance to seven students from each of the two medical schools in South Carolina. Other scholarships to be awarded are the Stuckey Scholarship to a student from Bamberg County; three scholarships contributed by a cardiology group from Spartanburg; and the Conway Hospital Medical Staff Scholarship. Also this year, one scholarship (Annie Fair) will be awarded to a student from Greenville. A \$2000 award will be presented to a medical student for best research project.

Each student at both South Carolina medical schools received a letter from SCIMER in January announcing the scholarship availability and the procedures to apply.

SCIMER would like to express appreciation for the financial support provided by those of you who paid an extra \$25.00 on your dues billing this year.

Last year, we endorsed two new projects for the benefit of physicians in the state. First, the Section 170 Plan, unique to SCIMER, was made available to South Carolina physicians in the fall of 1993. We can offer physicians this charitable annuity, among other benefits, thus ensuring guaranteed income for life. During the past year, this program has been very successful and will be a tremendous benefit to SCIMER in the future. Second, in February, 1994, SCIMER joined Sister-city to collect used office furniture, medical equipment and supplies to be shipped to Plovdiv, Bulgaria. This will enable their country to improve its medical technology. Last year, several contributions were made to this cause.

Finally, I would like to express my sincere

thanks to the members of the Board of Directors for the time and effort they have given to this worthwhile activity.

Alexander Donald, MD
President

REPORT OF THE SCMA DELEGATION TO THE AMA

During the past year the South Carolina Delegation to the American Medical Association (AMA) has continued to function as a visible and dedicated unit, representing our physicians well on the national level. Delegates Dan Brake, MD; Chris Hawk, MD; Charles Duncan, MD; and I, and Alternate Delegates John Simmons, MD; Steve Imbeau, MD; Roger Gaddy, MD; and Nelson Weston, MD; have been aided in this representation by President Marion Burton, MD; President-Elect Ned Nicholson, MD; Secretary Bryan Walker, MD; and Treasurer Carol Nichols, MD; at AMA meetings. Utilizing this talent and dedication fully, the delegation has reviewed and critiqued the hundreds of resolutions and reports which constitute the business of the AMA House of Delegates each meeting, debating and voting upon them in the fashion we feel best reflects the attitude and philosophy of the membership of South Carolina Medical Association (SCMA).

At the Annual Meeting in Chicago last June, I was privileged to serve as chairman of the Reference Committee on Constitution and Bylaws; and at the Interim Meeting in Honolulu, Dr. Charles Duncan was a member of the Reference Committee on Legislation. Bill Mahon and I continue to serve on the Managed Care Partnership Group, working with five other states and several specialty societies and developing AMA policy toward managed care. In addition, Bill is a member of a close-knit group of state executives who regularly meet with AMA Chief Executive Jim Todd, MD, in molding and directing implementation strategies for the AMA House of Delegates and Board of Trustees. Such appointments and services are a compliment to and recognition of the quality of our AMA Delegation, in my opinion.

This year Dr. Randolph Smoak completes his first three-year term as a member of the AMA

Board of Trustees. It is unerringly clear that Randy is steadily ascending in national prominence in organized medicine. This year he was elected member-at-large of the board's Executive Committee and appointed the very important chairmanship of the board's Finance Committee. He has become AMA's spokesman on many important issues, highly visible in the AMA program to make America free of the ravages of tobacco-caused illnesses by the year 2000. South Carolina has every right to be proud of Dr. Smoak and secure that we are heard prominently in national affairs because of him. At present, Randy is unopposed for reelection to the board.

Following a study completed last year, major changes have been undertaken this year in the organizational structure of AMA. This is being done in an effort to make AMA a "leaner," better functioning and less costly operation. There has already been considerable downsizing in many areas, changes which project to a savings of as much as four million dollars annually for our organization. This restructuring has also led to delineation of chain of command and responsibility, in my opinion. Though the AMA continues to increase in membership, the increase-marginal, I might add income from either sources has fallen. Notable in this regard is income from pharmaceutical company advertising in the AMA's many journals and other publications, which has decreased dramatically.

As I have reported to you in *The Journal of the South Carolina Medical Association* following each AMA meeting, this has been an epochal, perhaps even pivotal year for medicine in this country. Certainly the most important event has been the failure of the Clinton Administration efforts to implement health care reform. Although many physicians view this as something of a success, it should be remembered that the need for some changes in health care delivery was addressed initially by physicians in the AMA's Health Access America publication, that much of President Clinton's plan for "reform" was taken from proposals in that publication, and that many of the worthwhile goals for physicians and for the practice of medicine in the future still may be achievable in some "reform" initiative.

The AMA is therefore still committed to some effort at "incremental reform," including tort reform, changes in the singularly unfair anti-trust laws as they apply to physicians and to the insurance industry, and continued advancement of the Patients Protection Act nationally, in order to protect our patient's ability to select their own physician, and to assure patients that quality of care is not being sacrificed in the current frenzy to cut health care dollars.

The widespread nationwide burgeoning growth of "managed care" is being addressed by AMA in policy other than the Patients Protection Act. While most of us continue to feel that medical care is best delivered in a fee-for-service fashion, the AMA recognizes that managed care delivery seems to be here to stay. Living with it is not going to be always easy. Many physicians over the country, particularly on the west coast, are seeing the major portion of their income deriving from managed care entities. Many are forming their own managed care groups. Even in South Carolina we have formed the SCMA Physicians Care Network, recognizing that reality demands our involvement. The AMA Council on Ethical and Judicial Affairs (CEJA) has established standards accepted by the AMA House of Delegates which delineate the managed care entities' obligation to disclose carefully to the patient what benefits he truly enjoys and outlines for the physician what his obligations are to the patient while working in this managed care environment.

The AMA continues to be a powerful organization, easily the most powerful medical organization in the world. This power not only extends to the political and legislative arena, but to the educational arena, and to the arena in which ethical standards are set. Our strength resides in membership, and the dedication of that membership. Always the foremost premise of the AMA is to do what is best for our patients, the premise which exists in the heart and mind of every practicing physician, we pray. Your AMA delegation is committed to that premise and will do its best to represent you as well as we can.

Walter J. Roberts, Jr., MD
Chairman

REPORT OF YOUNG PHYSICIANS' SECTION

The 1994-95 year has been exciting on both a national and a statewide level. Nationally, after an intense grassroots lobbying campaign by members of the Young Physicians Section (YPS), the American Medical Association (AMA) Board adopted the resolution calling for a designated position on the Board of Trustees for a physician under the age of 40. A representative of the YPS will be elected at the Annual Meeting in June, 1995. This should insure that the interests, concerns, and perspectives of young physicians will always be a part of the Board of Trustees' deliberations. The South Carolina YPS was well represented at both the Annual Meeting and Interim Meeting by our delegate, Dr. March Seabrook (gastroenterology, Columbia) and our alternate delegate, Dr. Dina Grice (dermatology, Columbia). As in the past, both South Carolina Medical Association (SCMA)-YPS representatives were quite active in reference committees. On a statewide level, a bylaws change was enacted at the YPS Annual Meeting. This will allow the YPS Governing Council to be more streamlined and better able to respond to the needs of the section.

Several objectives were outlined by the Governing Council for the 1994-95 year. I am happy to report that these goals are well on their way to being achieved. They are briefly summarized below.

1. The YPS has had a representative on the Editorial Board of *The Journal* of the South Carolina Medical Association approved. After a statewide search by the council, Dr. Colin Howden (gastroenterology, Columbia) has been nominated and subsequently endorsed by *The Journal* Editorial Board. With his vast academic and research experience, the YPS Council is confident that the Dr. Howden will represent the section quite well.

2. In an effort to improve communication with

section members, a YPS Editorial Section has been added to the "SCMA Newsletter." The council is attempting to enlist the aid of as many contributors as possible on various topics of interest to YPS members.

3. In conjunction with Mr. Steve Williams, JD, the YPS Council has organized a series of regional conferences for SCMA members, entitled, "Strategies for Success in a Managed Care System." The first of these seminars was held in March in Columbia. Future seminars are planned in conjunction with local county medical societies.

4. Work is now in progress for the development of a statewide network of legislative key contacts. Interested physicians of any age are being recruited and encouraged to develop an ongoing personal relationship with their state senator and/or representative. The YPS Council is hopeful that this activity will greatly improve the involvement of all SCMA members in legislative activities.

5. Individually, members of the Young Physicians Section have been actively functioning on several SCMA committees, the board of the Physicians Care Network, and in recruitment activities. Presentations to interest groups such as medical students and residents regarding the activities and importance of the SCMA and AMA are ongoing. Also, ever increasing numbers of young physicians are becoming involved in the Doctor of the Day program.

In addition to these long range goals, the Young Physicians Section Council plans to increase membership recruitment efforts in the upcoming year.

Many thanks are due to the members of the YPS Governing Council for their expertise and their sacrifice of time and effort.

Richard A. Schmitt, MD
Chairman

AMA SPECIAL GUEST: RICHARD F. CORLIN, MD, VICE SPEAKER OF THE AMA HOUSE OF DELEGATES

Richard F. Corlin, MD, a gastroenterologist in private practice in Santa Monica, California, was reelected vice speaker of the American Medical Association (AMA) House of Delegates in June, 1994.

Dr. Corlin has been active in the affairs of the AMA for the past 16 years, having served for nine years as a member and then chair of the AMA Council on Long Range Planning and Development. He was also asked to chair the AMA Commission on Services to Young Physicians, which ultimately led to the creation of the Young Physicians Section in the House of Delegates. He served as chair of the AMA Study committee on Hospital Medical Staff, and has been a member and chair of AMA reference committees. He was a member of the Ad Hoc Committee on Physician Manpower from 1987 to 1988, and as a spokesperson for AMA, won the AMA Speakers Bureau Award in both 1980 and 1981, the last two years the award was given.

In 1992, Dr. Corlin was invited by the Secretary of Health and Human Services, Dr. Louis Sullivan, to serve as a member of the Advisory Committee to the Director of the National Institutes of Health.

Currently past president of the California Medical Association (CMA), Dr. Corlin served as its president from 1992 to 1993, was vice speaker and speaker of the CMA House of Delegates for nine years and a member of its Board of Trustees for 12 years. He was president of the Los Angeles County Medical Association (LACMA) Board of Trustees, and still serves as a member of the board.

Born in Newark, New Jersey, Dr. Corlin is a graduate of Rutgers University, and received his M. D. degree from Hahnemann Medical College. Following residency training at Hahnemann, Dr.

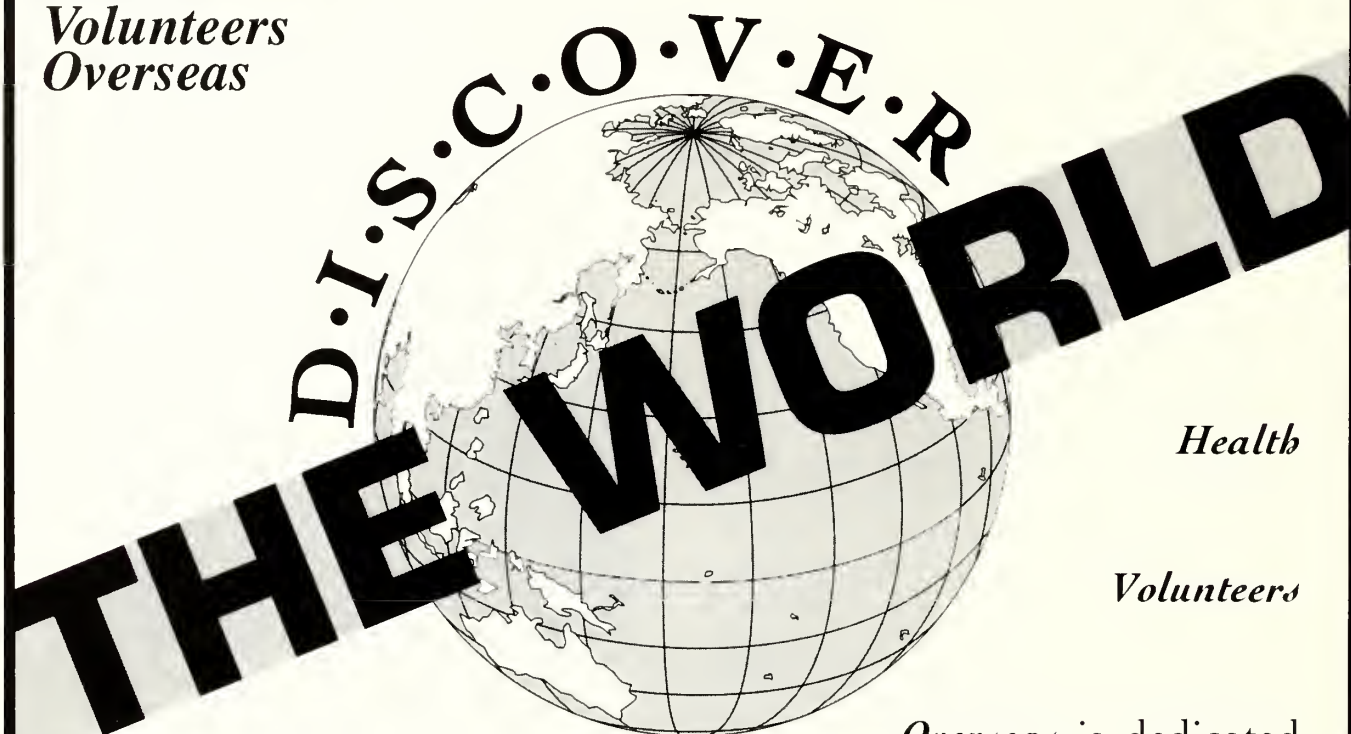


Corlin served as a Lt. Commander in the military service, USPHS, Heart Disease and Stroke Control Program from 1968 to 1970, and then took a gastroenterology fellowship at UCLA. He is a fellow of the American College of Physicians, a member of both the American Gastroenterology Association and the American Society of Internal Medicine, and a past president of the Southern California Society of Gastrointestinal Endoscopy. He is also an assistant clinical professor at the University of California, Los Angeles, School of Medicine.

Dr. Corlin, his wife Catherine and their son reside in Santa Monica.



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We think the non-cancelable policy will completely disappear in the next few months. Only a handful of companies write the product today; soon there will be none. The products that will replace the non-cancelable policies are starting to appear. We have examined them and can state unequivocally that they are not as good!

Actual claims experience on disability policies has been much worse than priced for. Companies are not able to adjust premiums on *non-cancelable* policies but in the future will be able to do so on new policies with adjustable premiums. You can review the increase on your health insurance premiums to get a feel for what will happen to disability premiums.

For the time being, SCMA Members are eligible for a 25% premium discount on

a *non-cancelable* policy with the highest quality definitions. Quite frankly, we don't know how long this product will be available but think it's very limited. If you would like to receive information about this product, please return the enclosed response. ***Time is of the essence.***

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ACKNOWLEDGMENTS

The SCMA gratefully acknowledges a contribution to defer meeting costs from The R. L. Bryan Company. The Residents Breakfast Meeting is compliments of the Resident Physicians Section of the AMA, and the Young Physicians Luncheon is compliments of the Young Physicians Section of the AMA.

The ice cream booth is compliments of Doctor's Care, and a refreshment break in booth #22 is compliments of Bell South Business Systems.

Editorials

Guest editorials reflect the opinions of the authors and do not necessarily represent the opinions of the officers and trustees of the South Carolina Medical Association.

— CSB

ORGAN AND TISSUE DONATION, MY PERSONAL EXPERIENCE

About 15 years ago, I was a practicing orthopaedic surgeon in a rural community in South Carolina. Having turned 40 and leaving a large group practice, the future looked promising. After a year and a half, my practice was growing and my family was happy with our new lifestyle. Our problem began with a form from the American Red Cross in September of 1982. Six weeks previously, my wife had donated blood for a neighbor. The letter thanked her for her donation but requested that she never give blood again. After further evaluation by a close friend, a gastroenterologist, we found that both my wife and I had been exposed to Hepatitis B. My children were vaccinated. He advised me to double glove during surgical procedures, go on with our normal lives, and return in six months for reevaluation. After six months, my wife had converted to the carrier state, but I had not and was classified as having chronic Hepatitis B. The advice was the same and this was confirmed by experts in Boston, New York and the National Institutes of Health (NIH). We were not aware of the possible long-term effects of being a carrier or having chronic Hepatitis B. The information was not available at the time, nor were there any directives from the Centers for Disease Control concerning invasive surgery. We returned once more to our gastroenterologist. In six months, the situation was unchanged and thereafter we saw our local internist.

It is now known that about 10 percent of adults and most children under the age of five (20 to 90 percent) do not clear the virus. If this occurs, a carrier state develops. Presently there are 1.5 mil-

lion asymptomatic carriers in the United States who may or may not have liver damage. About one percent go on to develop chronic hepatitis with varying degrees of cirrhosis which may lead to liver failure. Less than one percent of the chronic carriers develop hepatocellular carcinoma necessitating extensive care and follow-up.

The only problem I had between 1984 and late 1989 was the development of chronic progressive fatigue. Liver function studies remained normal and we did not make the connection between chronic Hepatitis B and the fatigue. We attributed it to working long hours in a solo practice.

In 1989, the fatigue had become so severe that I had to sleep during lunch breaks. One day while finishing a surgical procedure my hands began to shake uncontrollably. I finished suturing the skin but knew that I had to find out what was wrong with me before I attempted any further surgery. The next morning I went to the lab and the results revealed that my liver enzymes were 30 times normal with an elevated bilirubin. I immediately contacted my gastroenterologist and after evaluation that day, he said, "The fact that you are not dead is encouraging." He restricted my activities and my practice (no surgery, no new patients, just completing treatment of fractures). Shortly thereafter he referred me to the NIH and the University of Pittsburgh for their evaluations.

The news was not good. The physicians at the NIH advised me that I had, at most, five years to live but were willing to try me on a then experimental drug, Interferon Alpha 2-B. They gave the drug only a 20 percent chance of having any

effect. At the University of Pittsburgh, Dr. Thomas Starzl advised I undergo a liver transplant as soon as they could find a donor. I was fearful of a liver transplant and refused to believe the poor prognosis.

Reluctantly, I consented to be placed on the secondary transplant waiting list for a liver transplant, but returned to the NIH and started Interferon which was continued for 11 months. During this period my physical stamina deteriorated; my jaundice became worse (my wife describes me as taking on the hue of an aging piece of copper-bronze and light green). My enzymes decreased as did the amount of viral reproduction. After 11 months the Interferon was discontinued and my condition gradually worsened. I did not convert to the carrier state while on the Interferon, but it did buy me a year. I returned to the University of Pittsburgh and was told that my only chance of survival beyond six months was a liver transplant. I was hesitant about a transplant because of the poor statistical results with Hepatitis B transplant recipients, about 45 percent survival the first year. By this time, all the other transplant centers had refused to consider me.

I was placed on the primary national waiting list in May of 1991. The first call came in about a week, but the liver was unacceptable when the surgeons inspected it. Home again and the waiting started again. The second call came in November of 1991, six months after the first call. By this time I had accepted death, feeling a donor liver would not be obtained and that I would not survive the surgery. After the emergency flight to Pittsburgh I was prepped for surgery as before, except this time the liver arrived from Washington, DC and was acceptable. The surgery began at 8:00 a.m. and lasted 16 hours. I was transfused with 40 units of blood and 14 platelet packs. My postoperative course was relatively uneventful except for an episode of acute psychosis attributed to the drug, Acyclovir.

I have survived three and a half years now with periodic bouts of Hepatitis B which is presently being treated with a new experimental antiviral drug that appears to be effective. There have been bouts of depression during this time with

which I am coping. At present I am off all my immunosuppressants except for FK-506 (Prograf) which was approved last year for liver transplants by the Food and Drug Administration. Although I am not able to return to my medical practice, I enjoy being an advocate for organ/tissue donation and spending time in my workshop making furniture for my childrens' homes and toys for my grandchildren.

Why have I related all of this to you? To encourage you to learn more about and to assist in the procurement of organ and tissue donation and transplantation. Certainly not a new field of medicine — the first skin graft was performed in 300 B. C. Because of new immunosuppressant drugs, better techniques and new technological advances (all leading to better survival rates at one and five years) transplantation has grown rapidly in the last 15 years.

But a fundamental problem exists: there is a lack of donated organs and tissues. Presently in the United States there are more than 37,000 people waiting for organ transplants (20 percent of whom are under age 18). At least 350 people are waiting for organs in South Carolina (this is a low estimate since it does not include South Carolinians listed at out-of-state transplant centers). There are an estimated 20,000 deaths per year in the United States that could provide donated organs and tissues to save lives that would otherwise be lost. Last year there were approximately 4,500 organ donors with 57 from South Carolina. These numbers have not changed significantly over the last five years. From these donors, approximately 18,500 organ transplants were performed. It is estimated that if one person would donate all of his/her organs and tissues, at least 50 individuals would benefit. Because of a lack of organs, seven to 10 people die each day (about 3,500) per year in the United States.

It is estimated that by the year 2010, five percent of the United States population will be an organ or tissue recipient. Every physician, from family practitioner to pathologist, is going to have to work with and treat transplant recipients. We are not oddities anymore, but people who have been given a second chance at life. Learn

about the diagnosis of brain death, cardiac death and what organs and tissues can be obtained from organ transplantation. Be supportive of patients and families who are considering organ and tissue donation. If you think you have identified a potential organ donor, call the South Carolina Donor Network at the number below. Let them decide if the candidate is acceptable and aid the family in their decision. A fully trained organ procurement specialist will contact you and will take care of the details.

Six years ago I knew nothing about organ donation and transplantation, but today I am a living transplant recipient. Some day possibly you, a loved one, your child or grandchild will require an organ transplant. Take the time to learn about

the basics concerning organ and tissue donation so that if the need ever arises for you, a loved one or a patient, you will understand the process.

You can make a difference. Every physician's office should have literature and donor cards available for their patients. The literature is free for the asking. Call a member of the South Carolina Donor Network: (1) American Red Cross Southeastern Tissue Service : 1-800-922-5986; (2) SC Lions Eye Bank: 1-800-476-1304; (3) SC Organ Procurement Agency: 1-800-462-0755. The life you save may be your own.

Larry McManus, M. D.

1463 Circle H Woods

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On the Cover:

ANNUAL MEETING SOUTH CAROLINA MEDICAL ASSOCIATION, 1895

The 45th Annual Session of the SCMA was convened at noon, April 24, 1895, in the Senate Chamber of the State House by President T. J. McKie of Woodlawn. After the usual preliminaries, Dr. L. C. Stephens of Barnwell gave an "able and exhaustive" (and exhausting?) report on "Epidemics," the upshot of which was that "since our last assembling, we, as a State, have had almost entire immunity from visitations of pestilential plagues."

Dr. McKie, in his presidential address, spoke to a variety of themes: the need to support the SCMA; the necessity of active interest of the medical profession as "guardians of the public health"—That they "stand side by side with the legislator to warn him of his duty and of danger when pestilence stalks abroad in the land"; the sad state of the practice of midwifery in the state and the need for training and licensing of the practitioners; and the enlightened idea that some "criminals" may, indeed, be psychologically irresponsible and not deserving of "hanging, elec-

trocution, or burning at the stake." Dr. McKie advocates instead "asexualization which changes the character without injuring the physical man." Realizing that there might be obstacles interposed by the Legislature, McKie mused that "It is a somewhat remarkable civilization that will break a criminal's neck, but will respect his testicles."

Dr. Simon Baruch, of New York, formerly of South Carolina, gave a paper on "'The Clinical Aspect of Dyspepsia,' illustrating his methods of stomach lavage, etc., with numerous tubes, appliances, etc."

Dr. J. L. Napier, having been duly elected president, was escorted to the chair. After hearing more papers and correspondence, the meeting adjourned.

The group was entertained on Thursday evening with a reception at the College for Women.

Betty Newsom
The Waring Historical Library



Alliance Page

LOOK BEYOND YOURSELF

Nearly a year ago, I challenged the members of the South Carolina Medical Association Alliance to "look beyond themselves" when approaching the 1994-1995 alliance year. This challenge was met with enthusiasm and eagerness by the county alliances and auxiliaries across the state.

The fall of 1994 began with Legislative Workshop in Columbia, S. C. State leaders, county presidents and legislative chairmen from the alliance were addressed by members of the South Carolina legislature. This informative day increased the desire of the alliance and SCMA to form a cooperative "grass roots" networking aimed at utilizing knowledgeable members to assist in lobbying efforts.

Our desire to increase funding to the medical schools found the AMA-ERF committee working to bring new and innovative fundraising ideas to everyone. The "Holiday Sharing Card," auctions, fashion shows, greenery sales, poinsettia sales and numerous activities were held to raise funds for MUSC and the USC School of Medicine. We look forward to presenting the "fruits of our labors" to the deans of these two schools at the SCMAA House of Delegates in Charleston. A drawing for a pair of Victorian stockings and the sale of baskets depicting of the local businesses of the counties will also add to our AMA-ERF contributions.

On February 2, 1995, the first statewide "Membership Symposium" was conducted for our Alliance. A member of the AMA Alliance Membership Committee, along with several of our county presidents, presented numerous ways to increase membership, retain members, and to plan membership drives geared toward the needs of each county. This meeting was said by one county president to have been "the best I've ever attended." The Membership Committee has taken their challenge "beyond themselves."

To bring a closer awareness to the escalating problem of Child Abuse, alliance members, their families and friends will gather in their towns across the state on March 25, 1995, to "WALK FOR THE CHILD." This has been the major emphasis for the Health Promotions Committee this year. On this date, the walks will be held, children's health fairs conducted and children who were abused and died will be remembered. We will continue to be supportive of the efforts to make the quality of life for all of South Carolina's children better. We will "Look Beyond Ourselves."

The immunization rate for children within our state has increased so that we are now the leader in the nation for childhood immunizations. The alliance was honored that one of our members headed a Governor's Task Force for immunization increase.

The continued work of South Carolina's Child Protection Advisory Committee was honored by the Kellogg Foundation presenting the state of South Carolina with a \$3 million grant for their work in welfare reform. The Child Protection Committee was formed by the SCMAA in 1970s and is still a vital part of our organization. When making the presentation, a representative of the foundation stated that this award was due to the work of the SCMA Alliance. The Art Expression Day, under the leadership of past-president Betty Hester, brought the Alliance to the forefront of the nation at this time. Our members still "look beyond themselves."

As a new year for the Alliance begins, I encourage each medical society to support the alliance/auxiliary within your county. They are the force to see that the needs of our counties are being met.

It has been my honor to have served as SCMAA President for 1994-1995. The support of the SCMA and its staff had been invaluable. I still challenge each of us to "Look Beyond Yourself."

Mrs. Stoney A. Abercrombie (Donna)
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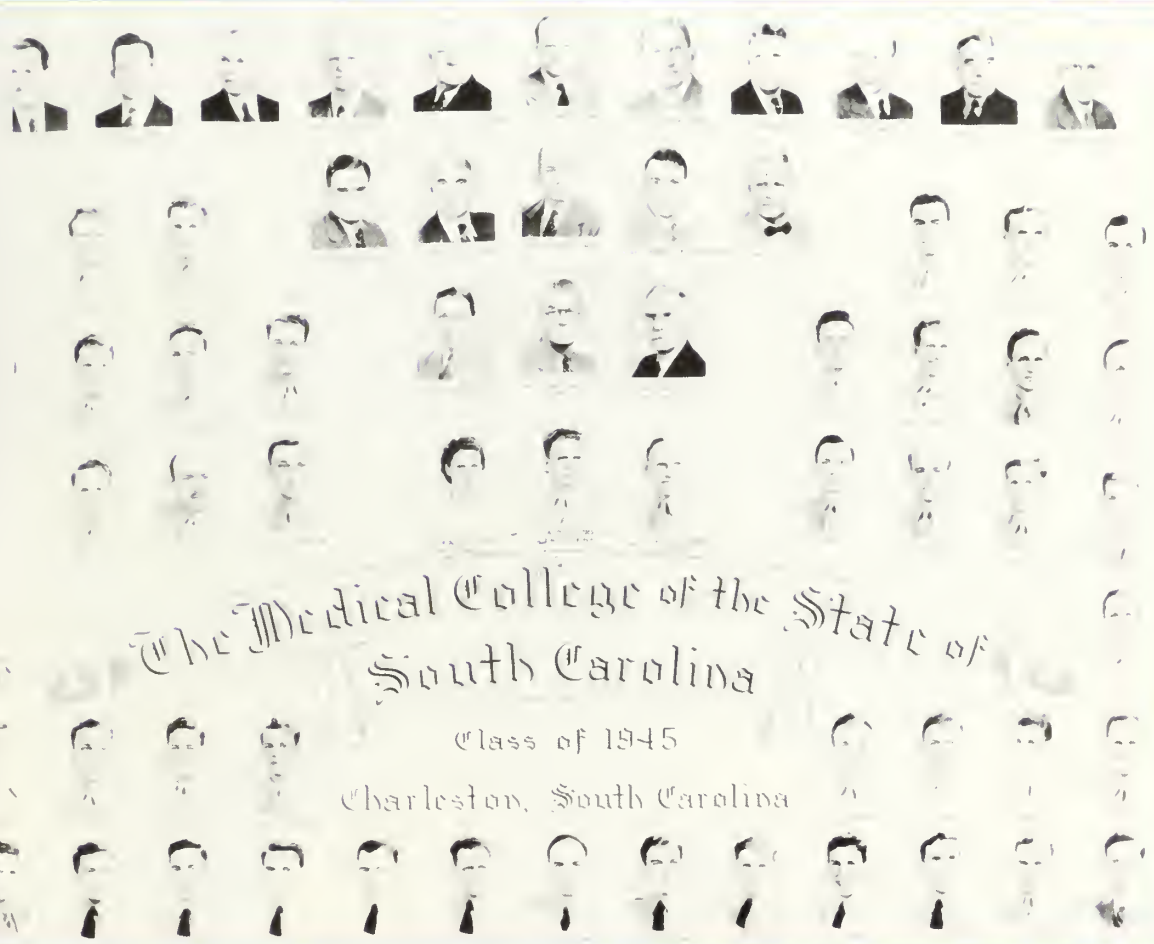
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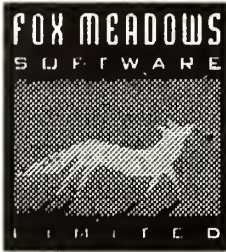


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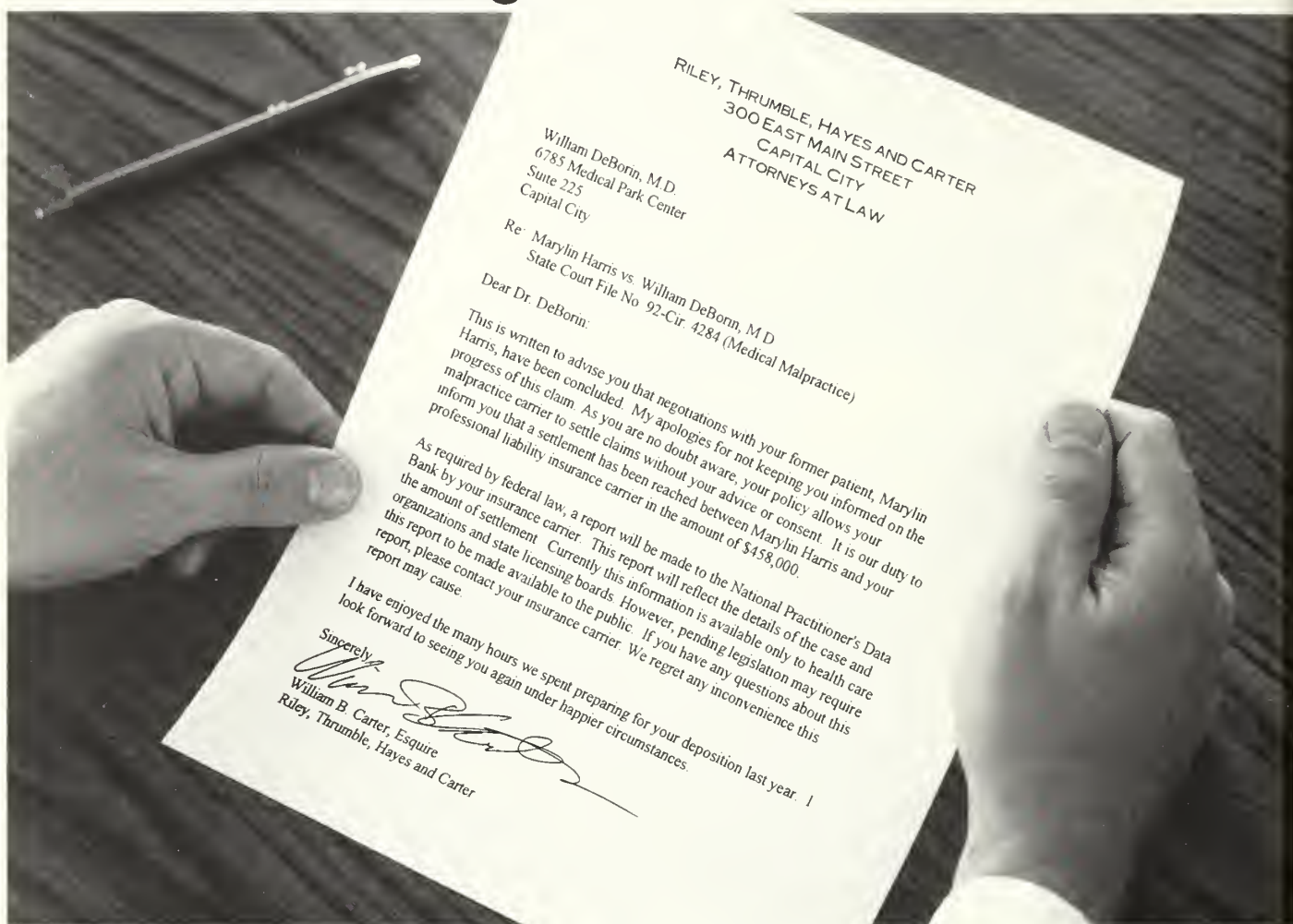


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President's Page

STOP HURTING — START HEALING

It may shock some of you to learn that our small state is ranked fifth nationally in violent crime and that the four states ranked above us all contain very large cities. We are ranked second per capita in aggravated assaults, eighth in rapes, and 12th in murders. Approximately three-fourths of these rapes, murders, and assaults are committed by family members and acquaintances. Over 22,000 cases of criminal domestic violence were reported to South Carolina law enforcement officers in 1992. Nationally, every 10 years, violence takes the lives of as many women as the total number of Americans who died in the Vietnam War. Two thousand American children are beaten and starved to death every year and a million more suffer some type of abuse. Some studies estimate that physicians fail to properly identify as many as 95 percent of victims of domestic violence. I know that this last statistic sounds as though it can't be true, but I think it may be. I never had a lecture on family violence in medical school. I did not know what resources were available, and I certainly did not know what role the physician should play in these situations. All these facts, in additions to numerous episodes of abuse that I have encountered in my years of practice, have convinced me that something needs to be done.

I am adopting violence-free families as the theme of my presidency. Family violence is a terrible and troubling part of our modern society which touches all age groups and social classes. It can include physical, sexual, and emotional abuse and the results are often devastating. The victims, who range from the very young to the very old, can become isolated from the outside world, severely restricting their personal freedom and making them lose their belief that anyone can help them. It is such a disturbing problem that we all have been very reluctant to face it. But it exists. Until now, there has been no real coordinated effort between private and public sectors in South Carolina to address the issue of family violence. The South Carolina Medical Association and invited agencies hope to change this. We intend to:

1. Establish the South Carolina Coalition For Violence-Free Families charged with developing a reference book and identifying the gaps in the present system related to family violence;
2. Educate physicians to recognize the signs of various kinds of abuse and provide them with the management objectives for dealing with it; and
3. Encourage victims to confide in their physician.

During the coming year, we will be calling on you to help us with this ambitious family violence agenda. The patients concerned, some of whom are among the most vulnerable and helpless of those we see, need our sympathy and professional help. And isn't that, my fellow physicians, the real reason why we went to medical school?

A handwritten signature in cursive script that reads "Ben Nicholson". The signature is written in dark ink and has a long, sweeping underline.

Benjamin E. Nicholson, M. D.
President

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THE MUSC LUNG TRANSPLANTATION PROGRAM: THE FIRST YEAR'S EXPERIENCE*

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JOHN R. HANDY, M. D.

Lung transplantation for selected patients with end-stage lung disease has only been achievable since 1983.¹ Clinical experience in lung transplantation has accelerated rapidly since the end of the last decade. The Medical University of South Carolina (MUSC) has developed a lung transplantation program that began in July, 1993. Since that time we have performed five lung transplant procedures. In this article we report our early experience of lung transplantation at MUSC.

METHODS

Patient Selection

Between July 1, 1993 and August 31, 1994, 118 patients were referred for consideration of

lung transplantation. Thirty-seven of these patients were evaluated in our transplant clinic. Our criteria for lung transplantation are similar to those of other centers and are listed in Table 1. Generally, these criteria are used to determine which patients are ill enough to warrant lung transplantation yet are well enough to tolerate the procedure. They also should be free of significant extra-pulmonary organ dysfunction.

Seven patients ultimately were listed for lung transplantation. Five patients have received lung transplants, one remains on the waiting list, and one patient died awaiting transplantation. Two additional patients were eventually listed for heart-lung transplantation: one of these remains on the waiting list and the other has died.

Over three-fourths of the 118 referrals were excluded from transplantation for one of four reasons: inadequate funding (24%), a medical contraindication (20%), the patient decided to forego transplantation (16%), and age greater than 60 (16%).

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TABLE I
CRITERIA FOR TRANSPLANTATION

Medical Criteria

Life expectancy from progressive pulmonary disease < 18 months
Age < 60 years
Absence of systemic disease with significant end-organ damage, especially liver and kidney damage
Absence of significant coronary artery disease
Not on high-dose corticosteroids (> 20 mg/day)
Adequate nutrition
Ambulatory
Abstinence from smoking for at least three months

Psychosocial Criteria

Demonstrates compliance with medical regimens
Psychologically stable; no history of alcohol or drug abuse or psychosis
Able to move to transplant center and maintain self plus support person for three months after transplant.

Preoperative Care

All patients listed for lung transplantation at MUSC are enrolled in a pulmonary rehabilitation program consisting of graded and monitored exercise using a bicycle ergometer and a treadmill. The purpose of this exercise program is to maximize the patient's fitness both physically and psychologically prior to transplantation. If arrangements for pulmonary rehabilitation cannot be made in the patient's local area, the patient is strongly encouraged to move to the Charleston area and enter our pulmonary rehabilitation program. Medical care is provided by physicians in the Pulmonary Division and the MUSC Lung Transplant Team.

Donor Selection

Criteria for donor suitability have been published.² In brief, there should be no history of pulmonary disease, no major thoracic trauma, age less than 55 years, normal chest radiograph and adequate oxygenation ($\text{PaO}_2/\text{F}_i\text{O}_2$ ratio greater than 350). We routinely examine the donor airways by bronchoscopy to assure the absence of purulent secretions.

Operation

Recipients are matched by size and blood type (ABO compatibility). Serologic reactivity to cytomegalovirus (CMV) is matched whenever possible, but CMV mismatching is not consid-

ered a contraindication to transplantation.

Our first five patients underwent single lung transplant described by Calhoun and coworkers.³ Perfusion and ventilation scans performed during the initial evaluation revealed the more severely affected lung; this was used to determine which lung would be transplanted. The airway anastomosis was performed using a telescoping technique whereby the smaller of the donor and recipient bronchus is placed one cartilaginous ring inside the other. Bronchoscopy was performed at the completion of the procedure to evaluate the airway anastomosis.

Immunosuppression

Our immunosuppressive regimen consists of corticosteroids, azathioprine, and cyclosporin. Methylprednisolone is given intravenously at a dose of 1000 mg intraoperatively and then 125 mg every eight hours for the next two days. The patient is then placed on prednisone at a dose of 0.5 mg/kg which is tapered to a daily dose of 5 to 15 mg over the subsequent two months. Azathioprine is started at a dose of 2 mg/kg/day and is adjusted to maintain a white blood cell count greater than $4 \times 10^9/\text{L}$. Cyclosporin is initiated intravenously during the transplant procedure and converted to oral dosing when tolerated. The dose is titrated to maintain serum trough levels (TDX monoclonal RIA assay) between 350-400 ng/ml for the

first six to 12 months after transplant and then 150-250 ng/ml thereafter.

Infection Prophylaxis

Intravenous ciprofloxacin and clindamycin is given preoperatively. These antibiotics are adjusted depending upon results from culture of the donor airway at the time of harvest. Ganciclovir is given as prophylaxis versus cytomegalovirus (CMV) for at least three weeks if either the donor or recipient is seropositive for CMV. Recipients receive life-long acyclovir, trimethoprim-sulfamethoxazole, and mycostatin as prophylaxis against *Herpes Simplex Virus*, *Pneumocystis Carinii*, and *Candida* species respectively.

Surveillance

Recipients begin to ambulate as soon as possible, usually by the third postoperative day. After the patients leave the hospital they remain in the Charleston area for three months for further convalescence. They are enrolled in the MUSC Pulmonary Rehabilitation program and exercise five days per week. Lung function is monitored daily with a home spirometer with instructions to contact the Lung Transplant Team if there is a 10 percent or greater decrease in FVC or FEV₁ from baseline.

Surveillance bronchoscopy with trans-bronchial biopsy is performed at postoperative weeks 2 and 4, then every three months for the

first year. Bronchoscopy is also performed for signs and symptoms suggestive of complications related to the transplanted lung; these include fever, shortness of breath, an infiltrate on chest radiograph, or a decline in spirometry.

RESULTS

Five lung transplant procedures were performed over the last year, all for obstructive lung disease (Table 2). One recipient (patient #1) developed acute lung injury in the immediate postoperative period and died of respiratory failure and disseminated intravascular coagulopathy nine hours after the transplant procedure. The subsequent four recipients (patients #2 through #5) had successful operations and were ambulatory without oxygen at the time of hospital discharge. These four recipients were all extubated within 24 hours, although one (patient #5) required reintubation on the third postoperative day because of a reimplantation response, a form of noncardiogenic pulmonary edema that occurs within the first four days after lung transplant.³ He was successfully extubated on the sixth postoperative day. The four successful recipients were hospitalized an average of 15 days (range 14 to 18 days).

These four patients are presently alive and well between two and five months after their lung transplants (Table 2). Spirometry performed three months after transplant has demonstrated a substantial improvement in pul-

TABLE 2
LUNG TRANSPLANT RECIPIENTS CHARACTERISTICS*

Patient #	Postoperative Days	Age	Sex	Diagnosis	Days on Waiting List Prior to Transplant	Outcome
1	1	51	F	Emphysema	34	Perioperative Death
2	166	48	F	Alpha 1-antitrypsin	55	Alive and well
3	142	28	F	Bronchiolitis Obliterans	65	Alive and well
4	116	53	F	Emphysema	24	Alive and well
5	57	50	M	Alpha 1-antitrypsin	2	Alive and well

*Data as of October 4, 1994

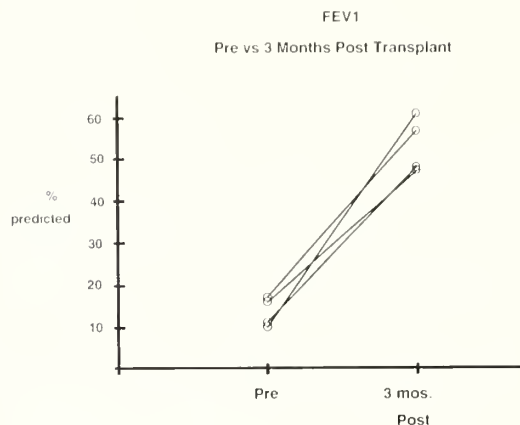


Figure 1. The forced expiratory volume in 1 second (FEV₁) is plotted for each of the four successful recipients pre- and three months post-transplant.

monary function (Figure 1). Similarly, the patients have realized significant improvements in their exercise tolerance as assessed by six-minute walk distance (Table 3). It is emphasized that prior to transplantation these patients required supplemental oxygen at high flow rates (two patients required 100 percent oxygen) during exercise. At this time all are fully ambulatory without requiring supplemental oxygen and have no limitations in performing the activities of daily living.

One patient (patient #4) developed mild acute rejection confirmed by bronchoscopic biopsy. This was associated with a 200 cc decline in FEV₁ and the development of oxygen desaturation with exercise. The patient was successfully

treated with intravenous corticosteroids for three days and an increase in her daily prednisone dose.

DISCUSSION

We report the first year's experience of the MUSC lung transplant program which has included the performance of the first four successful lung transplants in South Carolina. Presently these four recipients are in good health, fully ambulatory, and without complaints of dyspnea. Although these are early results, they are comparable to those of large international lung transplant registries.^{4,5}

One notable aspect of our lung transplant program is the relatively short waiting time. Our first five recipients were transplanted prior to accruing three month's time on the waiting list. Our waiting time is dramatically less than the median lung transplant waiting time in the United States of over 400 days (personal communication, United Network for Organ Sharing). The long waiting period is the result of limited donor availability and has resulted in the death of over 30 percent of lung transplant candidates on waiting lists.⁶ The short waiting time of our recipients is related to the small size of our waiting list. We suspect our waiting time will increase as more lung transplant candidates are enrolled by our program.

In conclusion, lung transplantation is a viable option for patients with end-stage lung disease. Ideal candidates are those under 60 years of age who are without evidence of extra-pulmonary


TABLE 3
SIX MINUTE WALK: PRE VS. 3 MONTHS POST-TRANSPLANT

PRE-TRANSPLANT			POST-TRANSPLANT	
Patient	Distance (feet)	F _I O ₂	Distance (feet)	F _I O ₂
2	1,000	100% NRB*	1,593	.21
3	1,555	100% NRB*	1,901	.21
4	1,610	NC-7 ^x	1,800	.21
5	1,310	NC-4 ⁺	1,740	.21

*NSB: Non-rebreathing mask

^xNC-7: Nasal cannula, 7 liters/min of O₂

⁺NC-4: Nasal cannula, 4 liters/min of O₂

organ dysfunction. Our early results with single lung transplantation have been highly successful and comparable to long-established centers. Although all our recipients have received single lung transplants, we are not exclusively limiting our program to this procedure; we will consider double lung transplants and heart-lung transplants in appropriate candidates. 

ADDENDUM

The four successful lung transplant recipients described in this report remain alive and well as of April 9, 1995. Since submission of this report we have performed three additional lung transplants and one heart-lung transplant.

REFERENCES

1. Cooper JD, Ginsberg RJ, Goldberg M, et al. Unilateral lung transplantation for pulmonary fibrosis. *N Engl J Med* 314:1140-1145, 1986.
2. Zenati M, Dowling RD, Armitage JM, Kormos RL, Dummer JS, Hardesty RL, Griffith BP. Organ procurement for pulmonary transplantation. *Ann Thorac Surg* 48:882-886, 1989.
3. Calhoun JH, Grover FL, Gibbons WJ, Bryan CL, Levine SM, Bailey SR, Nichols L, Lum C, Trinkle JK. Single lung transplantation. Alternative indications and technique. *J Thorac Cardiovasc Surg* 101:816-825, 1991.
4. Hosenpud JD, Novick RJ, Breen TJ, Daily OP. The registry of the International Society for Heart and lung Transplantation: eleventh official report - 1994. *J Heart Lung Transplant* 713:561-570, 1994.
5. St. Louis International Lung Transplant Registry. April 1994 report.
6. Hayden AM, Robert RC, Kriett JM, et al. Primary diagnosis predicts prognosis of lung transplant candidates. *Transplantation* 55:1048-1055, 1993.

HUMAN EHRLICHIOSIS: A CASE REPORT FROM THE SOUTH CAROLINA LOWCOUNTRY

MICHAEL M. HAWKINS, M. D.*

Human Ehrlichiosis is a tick-borne illness reportedly found most commonly in the south central and southeastern United States. It was classified as a "new disease" in 1986.¹ Some refer to the disease as "Spotless Rocky Mountain Spotted Fever." However, some patients may exhibit a rash involving the trunk and extremities.² Clinically, Ehrlichiosis is characterized by a history of tick bite or history of exposure to tick infested areas (without necessarily known history of tick bite), acute febrile illness, malaise, headache, myalgia, arthralgia, rigor, nausea, diarrhea, lymphadenopathy, confusion, and possibly pulmonary infiltrates. Lab abnormalities may include elevated transaminase and alkaline phosphatase, leukopenia, and thrombocytopenia.³ IgM and IgG titers can be obtained to help confirm the diagnosis if the disease is suspected from the history, clinical picture and laboratory data. Treatment is with Tetracycline, Doxycycline or Chloramphenicol, which should be started empirically if the diagnosis is suspected.

The purpose of this article is to report a case of human Ehrlichiosis diagnosed and treated at Colleton Regional Hospital in Walterboro, South Carolina, to increase physician awareness of this relatively "new disease" which I believe is likely more prevalent than currently reported. When a patient with a febrile illness gives a history of exposure to wooded areas or tick bite, it has become commonplace to test for Rocky Mountain Spotted Fever and Lyme Disease. However, the diagnosis of Ehrlichiosis should also be entertained since we are in an area where the disease is said to be prevalent.³

CASE REPORT

The patient is a 78-year-old white female with multiple medical problems including atrial fib-

rillation, advanced COPD, coronary artery disease, and hypertension (a true internal medicine patient), who presented to the office with an acute exacerbation of COPD. She was offered admission and refused, so was treated as an outpatient with close follow-up scheduled. Two days later, she was not any better and actually felt worse and agreed to admission to the hospital. Chest x-ray confirmed a pneumonia, and sputum gram stain showed moderate gram positive cocci and moderate gram negative bacilli along with abundant white cells.

She was started on IV antibiotics to cover gram positive and gram negatives, bronchodilators and Solu Medrol. Sputum cultures, sputum for AFB, blood cultures and urine cultures were all negative. The patient failed to show improvement after a couple of days, and her condition began deteriorating fairly rapidly. In an effort to identify an organism, bronchoscopy was performed and BAL was positive for *Pseudomonas*. Appropriate antibiotics were ordered and sensitivity studies were used to guide the choice of antibiotics.

Despite appropriate antibiotics according to C&S reports, the patient's condition did not improve much, and laboratory data revealed a progressing leukopenia and a thrombocytopenia. A bone marrow biopsy was unremarkable for any infection or neoplastic process. HIV screen was negative. The patient never had a rash, but constantly complained of aching all over. She was repeatedly questioned with regards to prior exposure, travel history, etc. When specifically asked about animals in the house, she indicated that she keeps dogs in the house and always sleeps with a dog in the bed with her. She admitted to finding a tick recently on her arm in the right axillary region. She was started empirically on IV Doxycycline and studies ordered for Rocky Mountain Spotted

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Fever, Lyme disease, and Ehrlichiosis. The Ehrlichiosis titers revealed a elevated IgM with a low titer IgG suggesting the presence of recent or current infection. The patient made a dramatic improvement within days. Her WBC and platelet count returned to normal. Her pulmonary infiltrate resolved. At the time of discharge, she was back to normal and continues to do well in follow-up.

DISCUSSION

One of the paramount lessons to me, in this case, is to keep pressing the history for clues when the clinical course is not unfolding as expected; ie this patient had pulmonary infiltrates and although an organism was identified and appropriate antibiotics started, she was not improving as expected. The patient was very ill and I suspected would probably have never left the hospital had she not been treated with Doxycycline for a presumed tick-borne illness. Secondly, here in the southeast, especially the coastal regions, the diagnosis of Ehrlichiosis should be entertained when a patient presents with leukopenia and/or thrombocytopenia. The

pertinent history should include questions regarding exposure to wooded areas, animals, as well as history of tick exposure. Remember, too, that patients with tick borne illnesses do not always give a positive history of tick bite. (I have had one patient this year with Rocky Mountain Spotted Fever with positive serology who visited wooded areas often, but never remembered finding a tick). Finally, if there is a clinical suspicion, start the Doxycycline or Tetracycline and wait for the tests to come back. If you wait for the lab results, you may end up with an undesirable outcome. □

REFERENCES

1. Macda K, Markowitz N, Hawley RC, Ristic M, Cox D, McDade JE. Human Infection with Ehrlichiosis Canis, a leukocyte rickettsian. *New England Journal of Medicine*; 316:853-C, 1987.
2. Theodore E. Woodward. Rickettsial Diseases. Isselbacher, Braunwald, Wilson, Martin, Fauci, Harper. *Harrison's Principles of Internal Medicine*, 756, 1994.
3. Eng Tr, Harkess, Jr, Fishbein DB, Dawson, JE, Greene CN, Redu, MA, et al. Epidemiologic, clinical, and laboratory findings of Ehrlichiosis in the United States, 1988. *JAMA*; 264: 2251-8, 1990.
4. Fishbein DB, Dawson JE, Robinson LE. Human Ehrlichiosis in the United States, 1985 to 1990. *Ann Int Med*; 120: 736-743, 1994.

SELECTIVE SPINAL INJECTIONS

DONALD R. JOHNSON II, M. D.*
STEVEN C. POLETTI, M. D.

Historically, epidural steroid injections have provided anesthetic relief for surgical procedures and childbirth. More than 60 years ago, it was recognized that the therapeutic benefits of such injections could be extended to the treatment of patients with low back pain. However, there is growing evidence that these anesthetic techniques are not directly applicable to the patient with low back pain. In this paper, we will discuss the indications, techniques of administration, and diagnostic and therapeutic benefits of spinal injections for low back pain.

INDICATIONS FOR SELECTIVE SPINAL INJECTION

The typical epidural steroid injection can bathe several intervertebral levels, thereby resulting in a comprehensive anesthetizing effect on the spine. However, for patients with low back pain, a more localized injection is often helpful in determining the etiology of the patient's pain, and thus clarifying the diagnosis. Just as internal derangement of the knee is no longer considered an acceptable diagnosis for patients with knee pain, lumbago should no longer be acceptable as a diagnosis for low back pain. Back pain may emanate from many anatomic structures, such as facet joints, sacroiliac joints, hip joints, discs, or the nerve roots.

To address the problem of pain localization, as well as to insure that injections are in the desired location, spinal injections should be done under fluoroscopy. Fluoroscopy allows accurate placement of the injection into any anatomic structure suspected to be the source

of the patient's pain. White et al.² have demonstrated that experienced anesthesiologists missed the epidural space 25 percent of the time when they performed epidural injections without the benefit of fluoroscopy. The reasons for this may include decreased interlaminar space, as commonly seen with spinal stenosis, postoperative scarring, obesity, and previous spinal fusions.

TECHNIQUES OF ADMINISTRATION AND DIAGNOSTIC BENEFITS

Since January of 1991, the Carolina Spine Institute has performed over 4,000 selective fluoroscopically-guided spinal injections.³ All injections are done in a spinal injection suite specifically designed for the use of fluoroscopy and equipped with a digital C-arm fluoroscope which provides high image magnification in detail. Prior to patient injection, an examination by a physician, and often a spinal physical therapist, is made to assess the most likely sources of pain. The clinical assessment is correlated with a review of electrodiagnostic information and any pertinent imaging studies, particularly CAT scans and MRI scans, to make a presumptive diagnosis of the patient's pain generator. The patient is then taken under fluoroscopy. The skin is anesthetized with 1% Xylocaine and injections are made into the presumed pain generators. Needle placement is usually verified by the injection of omnipaque 240 contrast dye, followed by an injection of 1% Xylocaine in a steroid solution, usually Depo Medrol. The patient is then taken from the fluoroscopic table to an adjoining waiting room, where a post-block examination is done to assess the immediate effect of the injection. The patient is asked to reproduce his typical discomfort, usually through a

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Figure 1. Cervical Selective Nerve Root Injection. (A) Needle; (B) Cervical Nerve Root with contrast (radiculogram).

series of movements such as bending, twisting, walking, or sitting. Changes in the patient's discomfort provide immediate feedback to both the patient and therapist and helps to identify the etiology of the patient's low back pain. After being monitored for 15-30 minutes, the patient is discharged home.

Selective spinal injections can be placed into the sacroiliac joints, facet joints, epidural space, nerve roots, discs, or congenital bony anomalies. One of the more common selective spinal injections is the selective nerve root injection. To perform this injection, the patient is placed in a prone position under fluoroscopy. The nerve root exits the spine below its adjacent transverse process and lateral to its adjacent pedicle. After the skin is anesthetized, an 18-gauge needle is placed just inferior to the base of the transverse process, slightly lateral to the pedicle and just deep in the coronal plane to the intertransverse membrane. A 22-gauge spinal needle is then threaded through the 18-gauge needle into the exit zone of the neural foramen. Contrast dye is injected and a radiculogram is reproduced under fluoroscopy. For example, a patient with a right L5 radiculopathy secondary to a disc herniation would undergo a right L5 selective nerve root injection. When contrast is injected over this nerve root, the patient's typical pain is immediately reproduced. Then one to three cc's of 1% Xylocaine, as well as 60-80 mgs of Depo Medrol

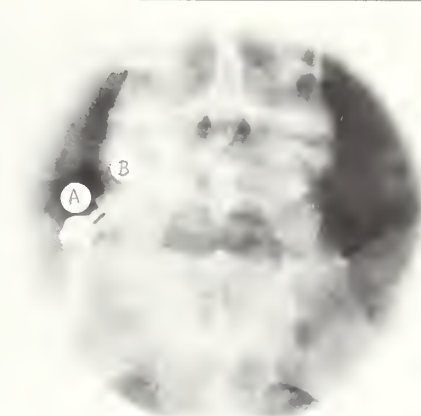


Figure 2. Lumbar (L5) Selective Nerve Root Injection. (A) Needle; (B) Lumbar Nerve Root with contrast (radiculogram).

are injected. Within seconds, the patient's discomfort is diminished as the anesthetic solution is absorbed. An assessment of the injection's efficacy is made within 5 to 15 minutes, as described above. If the patient's pain is largely resolved, then we can be reasonably certain that irritation of the L5 nerve root is the source of the pain.

Derby⁴ has shown that patients who receive immediate pain relief with selective nerve root injections, often benefit from surgical decompression of the root. Conversely, patients for whom there is no relief of pain after selective nerve root injections have poor surgical outcome. Selective nerve root injections can also be given to patients with a history of previous spinal surgery. For this group of patients, epidural injections are often impossible because of the large amount of epidural fibrosis and bony mass from fusions. However, selective nerve root injections may be very helpful. We have found this technique to be extremely useful in post-operative patients and often is the only technique available to deliver medication to painful nerve roots.

THERAPEUTIC BENEFITS

In addition to the diagnostic benefits of these selective spinal injections, we believe these injections often have a substantial therapeutic benefit.⁵ We are currently reviewing a large group of patients with herniated discs and

free fragments in the epidural space who have been treated conservatively with such injections and physical therapy rehabilitation exercises, and have made complete recoveries without surgery. However the utilization of these selective spinal injections should be placed in the continuum of care which includes thorough examinations, appropriate imaging, electrodiagnostics, and active therapeutic rehabilitation, as well as education. While these injections in and of themselves are not a total medical treatment or cure for any back problem, they can be a very effective form of treatment.

It has been proposed by others that maximal therapeutic benefits are obtained through a series of blocks, consisting of three to seven injections performed one week apart. However, there is no current medical literature to support such a proposal. In our experience, selective injections can dramatically reduce the number of injections required: only 50 percent of our patients require a second injection, and only five percent require a third injection.

In conclusion, we feel that selective fluoroscopically-guided spinal injections are the current state of the art for epidural anesthetics and steroids delivery. When combined with other treatment modalities, they may be therapeutic, as well as diagnostic. By using these injection techniques, the need for many types of spinal surgeries can be avoided. □

REFERENCES

1. Mooney V: Where is the pain coming from? *Spine* 12:754-59, 1987.
2. White A, Derby R, Wynne G: Epidural injections for the diagnosis and treatment of low-back pain. *Spine* 5:78-86, 1980.
3. Poletti S, Johnson D: The use of diagnostic injections in the cervical and lumbar spine. North and South Carolina Orthopedic Society, Charleston, SC. June 1992.
4. Derby R: Diagnostic block procedures: use in pain localization. *Spine: State of the Art Reviews*. 1:47-64, Sept. 1986.
5. Stanley D, McLaren MI, Euinton HA, Getty CJM: A prospective study of nerve root infiltration in the diagnosis of sciatica: a comparison with radiculography, computed tomography and operative findings. *Spine* 15:540-43, 1990.



SCMA NEWSLETTER

A PUBLICATION OF THE SOUTH CAROLINA MEDICAL ASSOCIATION

Joy Drennen, Editor

798-6207, in Columbia

Contributions welcomed

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May 1995

HIGHLIGHTS OF APRIL BOARD OF TRUSTEES MEETINGS

At the April 20, 1995 meeting of the SCMA Board of Trustees held during the 1995 Annual Meeting, the SCMA board voted to contribute \$5,000 to AMA's efforts to pass federal legislation to cap non-economic damages in medical malpractice cases at \$250,000. The SC JUA will underwrite one-half of this contribution.

The board also voted to assist AMA in establishing a national litigation center. The purpose of the center is to provide a national shared effort by all state medical societies in preparing for future legal issues affecting physicians.

Reorganization Meeting: At its reorganization meeting immediately following the *sine die* adjournment of the House of Delegates on Sunday, April 23, 1995, the board elections took place as follows:

S. Nelson Weston, MD, Chairman

Richard E. Ulmer, MD, Vice Chairman

Patricia P. Westmoreland, MD, Clerk

J. Capers Hiott, MD, Executive Committee Member-at-Large



MEDICARE UPDATE

By now the May 1995 *Medicare Advisory* has been published. Included in this *Advisory* is the registration form for a Basic Billing Workshop to be held at the Embassy Suites Hotel on July 12, 1995, from 9:00 am to 4:30 pm. The cost is \$30 per person. Also included are coding tips, claims filing updates and much, much more. You and your staff should read this *Advisory* carefully.

Screening Mammogram: HCFA is conducting a consumer information initiative to encourage screening mammograms for female Medicare beneficiaries. Medicare covers the performance and interpretation of screening mammograms every one to two years depending on the beneficiary's age and risk factors. As part of the mammography campaign, HCFA has developed informational material regarding the benefits of mammogram, as well as Medicare coverage issues. The materials available include:


- Medicare claims data showing 1992-1993 mammography utilization rates by state and by race;
- HCFA brochure (in English and Spanish) telling older Americans about the benefits of Medicare-covered mammograms;
- Posters supporting the mammography campaign;

- Fact sheet on HCFA's Consumer Information Strategy and the Medicare mammography benefit, and
- "A Woman's Guide on Quality Mammogram" from the agency for Health Care Policy and Research.

If you would like these materials, send a written request to: Mammography Information Packet, Medicare Part B Professional Relations Staff, Palmetto Government Benefits Administrators, P.O. Box 100190, Columbia, SC 29202-3190.

Diagnostic Mammography Update: In the September 30, 1994 edition of the *Federal Register*, the diagnostic mammography benefit did not include symptomatic men. HCFA published a corrected amendment in the March 16, 1995 *Federal Register* which restates the applicability of diagnostic mammography to men as well as women.

Interest Rate Update: The interest rate for overpayment and underpayments is 14.125 percent effective April 4, 1995.

Surgery Workshop: Don't forget to pre-register for the surgery workshops to be held in June. Details are in the April, 1995 *Medicare Advisory*. 

MEDICAID UPDATE

Telephone System Changes: In an effort to serve physicians better, the Department of Physician Services will pilot an automated telephone system beginning May 1, 1995. When calling, you will have five options from which to choose:

- Program Manager, with a Voice Mail option,
- Verification of recipient eligibility,
- Verification of check amount,
- Information regarding a sterilization claim, or
- The receptionist.

To directly reach your assigned program manager, it will be important that you are familiar with the correct spelling of your program manager's last name. Please refer to Section 307 of the Physicians Provider Manual for program manager assignments, which was recently revised and sent to you. Medicaid is interested in your opinion of the efficiency of this system. Please share comments and concerns with your program manager at (803) 253-6134.

Ambulatory Visits: Effective immediately, the Finance Commission will implement an affidavit process for providers receiving a 977 edit code (the frequency limit for ambulatory care visits has been exceeded). The Finance Commission will honor a Medicaid card when the card for the month of their visit indicates the recipient had six or fewer visits. The provider will have to certify this was true through an affidavit and attach a copy of the card before the claim can be processed. Further details will be forthcoming in a Medicaid Bulletin.

Family Planning Waiver Update: Effective June 1, 1995, the Family Planning Waiver does not cover treatment for routine side effects or complications associated with the various family planning methods. Treatment costs in these types of situations are the responsibility of

the patient.

Edit Correction Form: Effective with payment date June 2, 1995, the Error Correction Form will be revised and entitled "Edit Correction Form." The basic format of the form was not changed, however, several new fields were added and some of the field locations changed. Also, the word, "error" will be referred to as "edit." A bulletin with details of this change will be received shortly.

Prolonged Physician Services: Effective with dates of service on or after June 1, 1995, Medicaid will reimburse for prolonged physician service with direct (face-to-face) patient contact.

<u>CPT Code</u>	<u>Reimbursement</u>	<u>Frequency</u>
99354	\$26.00	1 per day
99356	\$26.00	1 per day

Documentation for CPT codes 99354 and 99356 must clearly indicate that the service was direct (face-to-face) contact between the physician and the patient for more than 30 minutes beyond the usual service for the level of E/M code billed. A bulletin will be forthcoming with a detailed explanation.

Physician Standby Services: Effective with dates of service on or after June 1, 1995, CPT code 99360 will replace codes 99150 and 99151 to report physician standby services not involving direct (face-to-face) contact. There will be a grace period from June 1, 1995 to June 30, 1995, during which time you may use either 99150, 99151, or 99360. Please refer to the forthcoming bulletin for more details. ☐

PALMETTO HEALTH INITIATIVE UPDATE

The State Health & Human Services Finance Commission and Legislative Medicaid Waiver Task Force have decided to withdraw South Carolina's 1115 waiver application from the Health Care Financing Administration (HCFA) which would have required all Medicaid recipients to enroll in a managed care plan. Rather, they intend to implement a Medicaid managed care system on a voluntary basis for the state's current Medicaid population.

During the next year, the state plans to (1) streamline the eligibility process; (2) implement several pilot projects for the Physicians Enhanced Program (PEP) and if successful, allow for expansion of the PEP to other physicians on a voluntary basis; (3) open the South Carolina Medicaid program to HMO participation on a voluntary basis; and (4) continue to work with all parties to ensure that a sound approach to managed care is designed for South Carolina.

If you have any questions, please contact Elizabeth Biggers statewide at 1-800-327-1021, ext. 236 or in Columbia at 798-6207, ext. 236.



HIGHLIGHTS OF THE 147TH ANNUAL MEETING APRIL 20-23, 1995 THE OMNI HOTEL, CHARLESTON, SC

Elections: The following officers and trustees were elected or reelected by the SCMA House of Delegates:

Carol S. Nichols, MD, President-elect
Bryan L. Walker, MD, Secretary
Stephen A. Imbeau, MD, Treasurer
Roger A. Gaddy, MD, Speaker of the House
William H. Hester, MD, Vice Speaker of the House
Richard E. Ulmer, MD, Trustee, First District
John B. Johnston, MD, Trustee, First District
George P. Cone, Jr., MD, Trustee, Third District
Boyce Tollison, MD, Trustee, Fourth District
R. Duren Johnson, MD, Trustee, Fifth District
J. Capers Hiott, MD, Trustee, Seventh District
Michael W. Holmes, MD, Trustee, Ninth District
J. Chris Hawk, III, MD, AMA Delegate
Roger A. Gaddy, MD, AMA Delegate
John W. Simmons, MD, AMA Alternate Delegate
Stephen A. Imbeau, MD, AMA Alternate Delegate
O. Marion Burton, MD, AMA Alternate Delegate

Awards: *Kathleen P. Flint, MD*, a rheumatologist in Columbia, was presented the 1995 Thomas A. and Shirley W. Roe Award for the best article by a practicing physician and published in *The Journal of the South Carolina Medical Association* for the past two years. *J. O'Neal Humphries, MD*, of Columbia, received the prestigious President's Award from outgoing president, O. Marion Burton, MD. According to Dr. Burton, during Dr. Humphries decade of tenure as dean of the USC School of Medicine, he became acquainted with and actually taught every medical student that graduated, and scores of graduates still consider Dr. Humphries a continuing mentor in their professional lives. *Euta M. Colvin, MD*, was presented a framed resolution from John R. Hunt, MD, on behalf of the JUA Board of Directors. The resolution praised Dr. Colvin for his dedicated work in the area of professional liability over many years. *J. Richard Sosnowski, MD*, received an award for his outstanding service on the SCMA Ethics Committee since its inception.

Resolutions: Several resolutions were adopted as follows:

- A resolution submitted by the SC Orthopaedic Association resolving that the SCMA rescind its endorsement of the HCFA RBRVS for reimbursement of physician services by the Workers' Compensation Commission was rejected.

- Another resolution submitted by the SC Orthopaedic Association resolving that the SCMA endorse a plan whereby fees for physician services in Workers' Compensation cases be annually adjusted for inflation was adopted.
- A resolution from the Florence County Medical Society regarding the PPC Fee Schedule Amendment was amended by the House to have the SCMA Board of Trustees and/or staff to prepare a report as soon as possible on the interpretation and ramifications of a March 31 Blue Cross letter (amendment to the Network Professional Agreements) and provide a clearing house for county societies as they analyze this issue. The House also asked the SCMA to seek possible options to reverse the Blue Cross decision and that the SCMA Board of Trustees be authorized to provide the necessary financial support for this activity. This amended resolution was adopted.
- A Newberry County Medical Society resolution which called for the SCMA to keep abreast of changes in health care alliances and delivery systems in South Carolina and inform its members of these developments was adopted.

Reports from the Board of Trustees: The House acted on the following reports from the SCMA Board of Trustees:

- The report regarding Direct Access to Specialists was editorially amended and adopted.
- A board report regarding School-Based and School-Linked Clinics was referred back to the Board of Trustees for further study with the reference committee's primary concerns being supervision by physicians and cost-effectiveness.
- The report regarding Any Willing Provider Legislation was amended and it was recommended that the amended Managed Care Improvement Act be submitted to the South Carolina General Assembly and that no action be taken on Senate Bill 384.

President's Theme for 1995-1996: Benjamin E. (Ned) Nicholson, MD, has adopted for his theme for 1995-1996 "Stop Hurting – Start Healing," a campaign against family violence. See the President's Page in this month's issue of *The Journal* for details. Dr. Nicholson was sworn in as the 132nd president of the South Carolina Medical Association during the President's Banquet on Saturday evening, April 22, 1995. □

WORKERS' COMPENSATION COMMISSION UPDATE

The SC Workers' Compensation Commission recently released the *1995 Medical Services Provider Manual*. The manual became effective May 1 and replaced the 1990 *Schedule of Fees for Physicians and Surgeons*. The new edition is based on the 1995 CPT codes and features completely rewritten narrative sections which carefully explain billing and payment policy. Other updates include new policies for pricing supplies and injections, and the adoption of the HCFA-1500 claim form for billing Workers' Comp. Copies of the manual are available from the commission's Medical Services Division for \$25 each. To assist billing and claims review personnel in understanding and using the new manual, the commission has scheduled regional workshops this month in Charleston, Aiken, Florence, Greenville and Columbia. *For more information, call the Medical Services Division in Columbia at 737-5741.*

THE CARE LINE

Helping women and children obtain the health care they need is a priority for the Care Line, South Carolina's Maternal and Child Health Hotline. In 1992, Care Line was recognized as one of six model Maternal and Child Health hotlines in the nation.

The main goal of the Care Line is improved access and utilization of health care and health-related services. The Care Line staff provides assistance and support to callers in gaining access to prenatal care, infant and child health care, care for children with special needs, family planning and birth control, and other related services. The Care Line is housed in the Division of WIC services at DHEC.

For more information about the Care Line or the services offered, please call 734-3350 in Columbia, or toll-free at 1-800-868-0404. □

CAPSULES

Jack W. Bonner, III, MD, Greenville, was inducted as a Distinguished Practitioner Member of the National Academies of Practice at the organization's Membership Symposium and Banquet in March in Arlington, VA.

William F. Schmidt, III, MD, Greenville, was presented the DHEC Volunteer Physician of the Year award during the SCMA Annual Meeting last month. The award was presented by DHEC Commissioner, Douglas Bryant.

SCMA WORKSHOP UPDATE

Since the last SCMA Newsletter was published, there has been a change in the June workshops on "Understanding & Negotiating Managed Care Contracts." Following is the updated schedule:

June 13, 1995	Charleston Marriott	Charleston
June 14, 1995	Sheraton Hotel	Columbia
June 27, 1995	Greenville Hilton	Greenville
June 29, 1995	Florence Civic Center	Florence

This intensive, one-day program is presented by Stephen P. Williams, JD, Senior Vice President and General Counsel of the SCMA. Participants will learn how to read and understand managed care contracts. Attendees will also review the particulars of negotiating contracts, especially medical liability issues. Physicians and office managers will review payment and contracting issues, including capitation, incentives, and point-of-service plans. SCMA member tuition is \$45.00

For more information regarding all SCMA workshops to be held this summer and fall, call Ginny Comer, extension 253, at 798-6207 in Columbia or 1-800-327-1021 statewide. □

APPLICATIONS OF SMALL WIRE EXTERNAL FIXATION

H. KEVIN JONES, M. D.*

Since its introduction to North America in the 1980s, the Ilizarov method of external fixation has revolutionized the treatment of many very difficult orthopaedic problems. This method of external fixation, which originated in the Soviet Union, has been used to lengthen bone through distraction osteogenesis. Dramatic results have been achieved in the treatment of fracture nonunions, bone defects, deformities, osteomyelitis, and limb length discrepancy.

Since the original Ilizarov device was developed in the Soviet Union, other small wire external fixators have been used successfully.⁹

MATERIALS AND METHODS

Between October, 1991 and November, 1993, 15 procedures were performed at Beaufort Memorial Hospital using small wire external fixators. Three different fixators were used (Ilizarov, Richards Medical; Fixamo Depuy; Monticelli-Spinelli, Howmedica). The following applications were utilized: fracture treatment, bone transport/limb lengthening, deformity correction, and arthrodesis.

The external fixators were assembled prior to surgery after careful pre-operative planning. Pre-operative planning included the use of multiple radiographs including oblique views, tracings of the bone configurations and scanograms when applicable. Each lower extremity procedure was done on a fracture table using calcaneal skeletal traction and either femoral skeletal traction or bolster under the knee.

Post-operatively, patients usually took part in external fixator adjustments especially when lengthening was involved. Patients were instructed on how to adjust the fixator

with wrenches and their progress was monitored on an outpatient basis both in physical therapy and the clinic. Physical therapy was initiated on the day after surgery to maintain joint mobility.

The external fixators were routinely removed in the operating room when healing was felt to be complete. C-arm was used to evaluate for healing at the time of fixator removal.

RESULTS

Fractures

Seven patients were treated for fractures. These included two tibial plateau fractures, two distal femur fractures, two tibial shaft fractures and one combination tibial plateau and tibial shaft fracture. Six of these patients went on to have solid unions of their fractures. One fracture did not heal. This involved a patient with an open tibial shaft fracture. He was treated with intramedullary rodding of the tibial nonunion at seven months after application of the external fixator. The fracture did subsequently heal.

Three patients were treated with bone lengthening techniques. One patient had sustained an open comminuted tibial plateau fracture with four inches of bone loss at the distal tibial shaft. The second patient had a three-year-old nonunion of the ulna secondary to a high velocity gunshot wound. The third patient had a limb length discrepancy secondary to high velocity gunshot wound to the knee resulting in premature physal closure of the distal femur and proximal tibia (Figure 1). Bone transport was successfully utilized in all three cases to restore length and, in one case, to accomplish healing of the nonunion.

Small wire external fixation was used for deformity correction in three cases: (1) genu

*149 Ribault Square, Beaufort, SC 29902.



Figure 1 (A). Radiograph of the left tibia of a 15-year-old female who has a recurvatum deformity secondary to a high velocity gunshot wound. The injury resulted in premature closure of the distal femoral and proximal tibial physes along with closure of the tibial tubercle apophysis. At skeletal maturity she was left with a 3.5 cm limb length discrepancy along with the knee deformity.

varum secondary to a tibial plateau fracture, (2) adolescent Blount's, and (3) genu recurvatum secondary to premature closure of the tibial tubercle apophysis (Figure 1). Each deformity successfully corrected with gradual adjustments on the fixator.

Arthrodesis was performed on two patients. One patient had an infected nonunion of an ankle fracture. Infected bone was resected after applying the external fixator. The device was then compressed to accomplish apposition of the distal tibia to the talus. A solid union was achieved with the osteomyelitis eradicated (greater than two years follow-up). The second patient had an infected revision total knee arthroplasty and had already undergone a failed arthrodesis with a unilateral fixator. Using the small wire external fixator in a



Figure 1 (B). Ilizarov apparatus was applied five years after the injury. Lengthening and deformity correction were accomplished through a proximal tibial osteotomy.

hybrid arrangement with half pins, again solid healing was accomplished.

Complications

The most common complication encountered in this series was pin tract infections. There were 11 such episodes. Each of these resolved with p.o. antibiotics. There were no cases of osteomyelitis from infected pin tracts. Loosening of the tensioned wires occurred twice. There was one quadriceps contracture in a patient with a severely comminuted open distal femur fracture. One patient developed osteomyelitis after an open fracture, but this was at the fracture site, and not a pin site. One patient suffered a refracture of the ulna after removal of the fixator when he struck the forearm against the edge



Figure 1 (C). Radiograph taken prior to fixator removal. Good regenerate bone is noted at the distracted osteotomy site.

of a door jam. This fracture went on to heal with immobilization. The same patient ended up with a 20 degree flexion contracture at the elbow, which was approximately 10 degree more than his preoperative contracture.

Return Visits to the Operating Room

As previously noted, all fixators were removed in the operating room. Three unplanned visits were made to make adjustments on the fixator.

DISCUSSION

Development of the Ilizarov technique has been a breakthrough in the treatment of difficult fractures, nonunions, osteomyelitis and limb deformities. We are now able to accomplish what was frequently not possible previously.

Small wire external fixators have been extensively used for the treatment of fractures.^{6,8,13,14} These techniques have been particularly helpful with comminuted intra-articular



Figure 1 (D). Radiograph of the left tibia after fixator removal. Recurvatum deformity is corrected and the length has been completely restored.

fractures.^{6,8} Most orthopedists clearly recognize the many pitfalls encountered in the open treatment of severely comminuted tibial plafond fractures. These include disastrous complications such as soft tissue necrosis and osteomyelitis. These complications can be avoided with minimally invasive techniques and early joint mobility using these external fixators. Intra-articular injuries at the knee have similar applications.

Limb lengthening with small wire external fixators now has a proven track record with many years of experience in the Soviet Union.^{6,8} Modifications have been successfully used in the United States and have, in some ways, simplified the technique.² These include using half pins and hybrid (half pins and small wires) arrangements. Limb lengthening obviously requires good patient cooperation, close follow-up, and aggressive physical therapy.

Bone transport procedures have been used

to solve some of the most recalcitrant orthopaedic conditions such as nonunion and osteomyelitis.^{1,3,6,8,10} With traditional forms of treatment such as muscle flaps, free flaps, bone grafting, and vascularized bone grafts many such patients have undergone multiple operations which ultimately did not succeed. Bone transport has offered a definitive solution to these difficult problems and frequently with only a single major procedure not requiring bone grafting.

Small wire external fixators allow for gradual deformity correction and adjustments, which are not possible with internal fixation.^{6,8,11,15} Recognizing this, it is still the author's opinion that this is not a first line of treatment when internal fixation techniques have a proven record and are more expeditious. Treatment of deformities with the Ilizarov techniques is still evolving in North America. Recent literature has discussed the use of preoperative measurement and calculations to accomplish a predictable deformity correction.⁴

Small wire and hybrid external fixators can be particularly useful in performing arthrodesis.^{6,8} As with deformities, postoperative adjustments can be made if alignment is not satisfactory. Another interesting technique, which has been used in ankle arthrodesis is the attachment of plates to the fixator, which are used as cutting jigs for resection of bone.⁵ This allows for precise cuts on the bone ends and better bony apposition at the arthrodesis site.

Complications, as reported in this series, are frequent with this technique.^{11,12,15} The potential for pin tract problems, wire loosening, and joint contractures is well recognized. More serious problems can be avoided by anticipating these complications and initiating early treatment. Complications may also become less frequent as the surgeon's experience increases.

CONCLUSIONS

The use of small wire external fixators can be very useful in the private practice setting for treating very recalcitrant orthopaedic problems. Careful preoperative planning and close

attention to details is essential. Potential complications must be anticipated and recognized early. If the above principles are followed, very gratifying results can be achieved.

REFERENCES

1. Cattaneo R, Catagni M, Johnson EE: The treatment of infected nonunions and segmental defects of the tibia by the methods of Ilizarov. *Clinical Orthopaedics and Related Research* 280: 143-152, 1992.
2. Green SA, Harris N L, Wall DM, Ishkanian J, Marinow H: The rancho mounting technique for the Ilizarov method. *Clinical Orthopaedics and Related Research*. 280: 104-116, 1992.
3. Green S A, Jackson JM, Wall DM, Marinow H, Ishkanian J: Management of segmental defects by the Ilizarov intercalary bone transport method. *Clinical Orthopaedics and Related Research*. 280: 136-142, 1992.
4. Green SA, Gibbs P: The relationship of angulations to translations in fracture deformities. *J. Bone and Joint Surg.* 76-A: 390-397, 1994.
5. Ilizarov Method Courses. Advanced Applications of the Ilizarov Technique.
6. Ilizarov GA: Transosseous osteosynthesis theoretical and clinical aspects of the regeneration and growth of tissue. Springer-Verlag, 1992.
7. Karger C, Guille JT, Bowen JR: Lengthening of congenital lower limb deficiencies. *Clinical Orthopaedics and Related Research*. 291: 236-245, 1993.
8. Maiocchi, Aronson: *Operative Principles of Ilizarov*, Williams and Wilkins, 1991
9. Monticelli G, Spinelli R: Distraction epiphysiolysis as a method of limb lengthening. III. Clinical application. *Clin Orthop* 154: 305-315, 1981.
10. Nagger L, Chevalley F, Blanc CH: Treatment of large bone defects with the Ilizarov technique. *The Journal of Trauma*. 34 (3) 390-393, 1993.
11. Nicholas R, Bell DF, Armstrong PF: Pediatric applications of the Ilizarov method. *Clinical Orthopaedics and Related Research*. 280: 72-80, 1992.
12. Paley D, Catagni M, Argenti F, Prevot J, Bell D, Armstrong P: Treatment of congenital pseudoarthrosis of the tibia using the Ilizarov technique. *Clinical Orthopaedics and Related Research*. 280: 81-93, 1992.
13. Schwartzman V, Martin SN, Ronquist RA, Schwartzman BA: Tibial fractures. The Ilizarov alternative. *Clinical Orthopaedics and Related Research*. 278: 207-216, 1992.
14. Tucker HL, Kendra JC, Kinnebrew TE: Management of unstable open and closed tibial fractures using the Ilizarov methods. *Clinical Orthopaedics and Related Research*. 280: 125-135, 1992.
15. Velazquez RJ, Bell DF, Babyn P, Tibshirani R: Complications of use of the Ilizarov technique in the correction of limb deformities in children. *J. Bone and Joint Surg.* 75-A: 1148-1156, 1993.

Editorials

EHRLICHIOSIS: MORE TICK-BORNE TERRORISM?

What is most remarkable about the case of ehrlichiosis described by Dr. Hawkins in this month's issue is not that the disease occurred in the South Carolina lowcountry but rather its life-threatening severity. First documented in the United States in 1986, ehrlichiosis has acquired a reputation as being a mild version of Rocky Mountain spotted fever: an acute undifferentiated febrile illness that responds to tetracycline therapy. Occasionally, however, it can progress to multisystem organ failure with features resembling those of the toxic shock syndrome.¹ Since the disease is probably endemic in South Carolina but usually unrecognized, a brief review seems appropriate.

Ehrlichia chaffeensis, a rickettsial organism that primarily infects the cytoplasm of circulating leukocytes, seems to be the sole cause of ehrlichiosis in the United States. The disease appears to be spread primarily, although not exclusively, by *Dermacentor variabilis* (the dog tick), and its primary geography resembles that of Rocky Mountain spotted fever with most cases occurring in the south central and south Atlantic states, Oklahoma, and Missouri. Approximately seven days after tick exposure, patients experience the onset of fever and headache often with malaise, myalgia, anorexia, nausea, and vomiting. A maculopapular or petechial rash occurs in about 20 percent of patients and affects the trunk, face, and extremities with usual (> 95 percent of instances) sparing of the palms and soles. Frequent laboratory findings include leukopenia, thrombocytopenia, and abnormal liver function tests. Infiltrates are sometimes present on chest x-ray. Most patients are not suspected initially of having a rickettsial infection. Although tetracycline (and also chloramphenicol) to limit both the duration and severity of the infection, prompt

therapy is the exception rather than the rule.² Unfortunately, there are at this time no practical, widely-available test by which one can confirm the diagnosis. Therefore, one must maintain a high index of suspicion especially during the summer months. A history of tick exposure can be obtained in at least 90 percent of patients with ehrlichiosis, who are usually males and who for unclear reasons tend to be older than patients with Rocky Mountain spotted fever. Americans' growing penchant for outdoor activities makes tick-borne disease a problem of increasing concern, and ehrlichiosis is simply the latest member of a growing list (Table).³ For example, ehrlichiosis was recently reported to be common in a suburban golfing retirement community; golfers with higher handicaps (who therefore were more prone to venture into the woods) were more likely to experience the disease!

The importance of considering the possibility of tick-borne disease cannot be over-emphasized. Failure to initiate presumptive therapy increases the likelihood that the illness will be more severe—as has also been shown for Rocky Mountain spotted fever and typhus. Features in the more severe cases include conjunctival hemorrhage, the acute respiratory distress syndrome (ARDS), hepatitis, encephalitis, disseminated intravascular coagulation, and shock. The message is clear: with undifferentiated febrile illnesses, especially during the summer months, *think tick* and *think tetracycline*. But remember that other causes of community-acquired nonspecific febrile illness include such entities as endocarditis, staphylococcal septicemia, and meningococcemia. Thus, in some cases it may be prudent not only to obtain baseline serology, start tetracycline, and arrange for close follow-up but also to

TABLE
OUR MAJOR TICK-BORNE DISEASES

<u>Disease</u>	<u>Agent (Classification)</u>	<u>Major Vector</u>	<u>Geography</u>
Rocky Mountain spotted fever	<i>Rickettsia rickettsiae</i> (rickettsial)	Dermacentor	Southeast, West, South Central
Ehrlichiosis	<i>Ehrlichia chaffeensis</i> (rickettsial)	Dermacentor, ? amblyomma	South Central, South Atlantic
Lyme disease	<i>Borrelia burgdorferi</i> (bacterial [spirochete])	Ixodes	Northeast, Wisconsin, Minnesota, California
Tick paralysis	Toxin (neurotoxin)	Dermacentor, amblyomma	Northwest, South
Tularemia	<i>Francisella tularensis</i> (bacterial)	Dermacentor, amblyomma	Arkansas, Missouri, Oklahoma
Babesiosis	<i>Babesia microti</i> , ? <i>B. equi</i> (protozoan)	Ixodes	Northeast
Relapsing fever	<i>Borrelia</i> species (bacterial)	Ornithodoros	West
Colorado tick fever	Coltivirus species (viral)	Dermacentor	West

obtain blood cultures and "cover" (generally with beta-lactam antibiotics) for other pathogens.

—CSB

REFERENCES

1. Fichtenbaum CJ, Peterson LR, Weil GL: Ehrlichiosis presenting as a life-threatening illness with features of the toxic shock syndrome. *Am J Med* 95: 351-357, 1993.
2. Fishbein DB, Dawson JE, Robinson LE: Human Ehrlichiosis in the United States, 1985 to 1990. *Ann Intern Med* 120: 736-743, 1994.
3. Spach DH, Liles WC, Campbell GL, et al.: Tick-borne diseases in the United States. *N. Engl J Med* 329: 936-947, 1993.

WHAT IS PROFESSIONALISM AND CAN IT BE MEASURED?

Medical practice in the 21st century will be fundamentally different from that which we have known. The role of technology will be extremely high, but the technology will focus increasingly on the prevention of disease and maintenance of organ function rather than crisis intervention. The focus of high technology will shift from hospitals to diffuse networks. Most physicians will practice in large organizations and will be reimbursed by capitation, salary, or some combination thereof. Success will be measured, at least in part, by cost-effectiveness. And through all of this the physician-patient relationship will change. One thoughtful reviewer suggests that in 1935, the physician-patient relationship was one-to-one; that in recent years it has been ambiguous; and that in 2005 it will be one-to-*n* (a concept that suggests that our responsibility is not just to the individual patient, but to all of society).¹ What do these dramatic changes portend for physicians as *professionals*? What do they mean for the medical *profession*?

"Profession" comes from *profiteri*, which in turn comes from *pro plus fassfateri*, which means to confess or own to. The original usage of "to profess" in English was to take the vows of a religious order. Thus, the meaning was "to declare openly." To claim to be a professional, then, is "to declare openly" certain attitudes, beliefs, or competencies. But what is a profession and what is not a profession? By one listing, no fewer than 170 occupations purport to be "professions." One authority describes "the professional project" as "the effort of an occupational group to organize itself to gain a monopoly over a service and control of the market so as to develop a demand for the service in the form it provides," the aim of which is "collective conquest of status."² There is general agreement, however, that to be truly "professional" there must be a dedication to the public interest that far transcends socioeconomic gain. A "profession" must meet three criteria: (1) specialized training gained through for-

mal education and apprenticeship; (2) public recognition of the ability to set and regulate practice standards; and (3) commitment to the public good beyond "the economic welfare of the practitioners."³

Is it possible to be more specific? What prompted this editorial was the publication by the American Board of Internal Medicine of *Project Professionalism*, an attempt to define and promote professionalism in the training of young physicians.⁴ The elements of professionalism were put forth as follows:

- *Altruism*, whereby the ruling principle is the patient's interest, not self-interest;
- *Accountability* not only to patients but also to society and to the profession;
- *Excellence* that includes commitments to exceeding expectations and to life-long learning;
- *Duty* whereby one acknowledges one's availability and responsiveness when "on call;"
- *Honor and integrity* whereby one refuses to violate personal and professional codes; and
- *Respect* for others.

What impressed me most about the document was the clear description of certain signs and symptoms that professionalism has been betrayed. These include:

- *Abuse of power*, that can be manifested by betrayal of the trust of patients and colleagues; by bias; by sexual harassment; and by breach of confidentiality;
- *Arrogance*, denoting a haughty self-importance;
- *Greed*, defined as the inappropriate aspiration of money, power, or fame, leaving little room "for understanding, compassion or other qualities necessary for the healing profession;"
- *Misrepresentation*, the conscious act of lying or fraud;
- *Impairment* without recognition or acknowledgement;

- *Lack of conscientiousness*, often consisting of doing "just enough to get by," such as waiting for the radiology report rather than going to see the x-rays personally; and
- *Conflicts of interest*, whether by self-referral, acceptance of gifts, inappropriate utilization of service, inappropriate collaboration with industry; or compromising the principles of clinical investigation.

The document concludes with specific recommendations for recognizing professionalism and lack thereof, supported by twenty vignettes of real-life examples.

As a third-year medical student, I was told that there were really only three questions of clinical relevance: (1) What is wrong with the patient? (2) What can I do for the patient; and (3) What will be the outcome? Thirty years later, I conclude that this list must be expanded to include: (4) What will it cost? and (5) What, specifically, must I do to behave in the best traditions of our profession? The overriding imperative of professionalism is to serve our fellow humans ably and altruistically. In recognizing that we often fall short, we are hardly

alone. As one reviewer put it: "The professions bitterly disappoint us for falling victim to the imperfections of human nature and human institutions. The professional spirit is a ray of hope in the lowering gloom."⁵ What is professionalism? How can we measure it? How can we foster it? That our medical organizations, at all levels, are paying increasing attention to these vital issues should be a source of comfort, a reason to rejoice, and an impetus for renewal. What is best for society is, after all, also best for us.

—CSB

REFERENCES

1. Greenlick MR: Educating physicians for the twenty-first century. *Acad Med* 70: 179-185, 1995.
2. Kultgen J: *Ethics and Professionalism* (Philadelphia: University of Pennsylvania Press, 1988), p. 100
3. Sullivan WM: *Work and Integrity: The Crisis and Promise of Professionalism in America* (New York: HarperBusiness, 1995), p.2
4. Stobo JD, Cohen JC, Kimball HR, et c.: *Project Professionalism* (Philadelphia: American Board of Internal Medicine, 1995).
5. Kultgen J: *Op cit.*, p. 372.

Letters to the Editor

To the Editor:

When physicians put down a diagnosis of "depression," it sometimes causes the patients problems with insurance. I found out that I really wasn't using the proper codes for filing insurance, and so I asked Dr. Roy Ellison, a member of the National Board of Examiners for Psychiatry and a former member of our

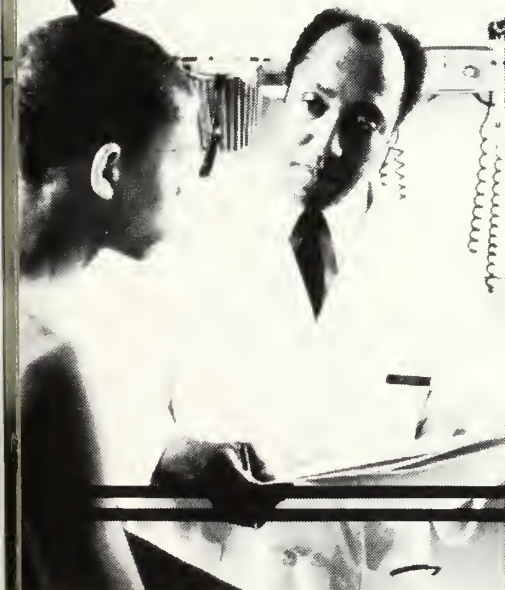
State Board, for help. He suggested the following:

I hope that my colleagues find this to be helpful.

William H. Hunter, M. D.
Clemson Medical Clinic
139 Anderson Highway 7, Suite 150
Clemson, SC 29631

Diagnosis	CTR Codes for diagnosis
Major depression (borderline psychotic)	300.4
Recurrent Major depression	296.2
Dysthymia (depressed several weeks)	300.4
Adjustment disorder (re: specific problems)	309.0
Adjustment disorder with mixed anxiety and depressed mood	309.28

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On the Cover:

FIFTY YEARS AGO

1945—Bataan retaken. Five hundred POWs freed. FDR dies of cerebral hemorrhage at Warm Springs, GA. Germany surrenders unconditionally. Atomic bombs dropped on Japan V-J Day, August 14. On radio, we listen to "One Man's Family," "Queen for a Day," and "Information Please." "The Lost Weekend" is the best picture of the year and Joan Crawford is voted best actress for her role in "Mildred Pierce." *The Glass Menagerie* opens on Broadway and Dizzy Gillespie tours the US with his first big band. We dance to "Cruising down the River" and relax with *Forever Amber* or *The Robe*, depending on our literary taste.

In medicine a method of administering penicillin orally is developed and scarlet fever is treated successfully. Six new antibiotics are developed. Taussig and Blalock pioneer "blue baby surgery."

In South Carolina, the Annual Meeting of the SCMA is canceled because of wartime restric-

tions. Physicians are still discussing the "fee for service" versus the compulsory insurance problem. Hilla Sheriff, Director of Maternal and Child Health, reports that there were 55 fewer maternal deaths this year than last. Now that penicillin is available on the open market, the feeling is that "it will be found to be one of the most powerful weapons in our armamentarium—but not a wonder drug."

At the Medical College, Dean Kenneth Lynch is beginning to launch his Expansion Program with plans for a Medical College Hospital. On June 15, 1945, members of the class of 1945 receive their M. D. degrees and most, their commissions into the army or navy. Following the ceremonies, the faculty hosts a reception in the library for the graduates and their families, with about 500 persons attending. This is the first of what it is hoped will be an annual event.

Betty Newsom

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Alliance Page

PRESIDENT'S ADDRESS 1995 SCMAA CONVENTION April 20, 1995

Thank you, Donna. Convention chairman, Union County Delegates, all my dear friends and associates in the South Carolina Medical Association Alliance, ladies and gentlemen.

It is difficult to convey to you the honor, privilege and thrill I feel at this moment. Thank you all for providing me this opportunity to serve you in this great organization. I pledge to you my best efforts and hope you will join me in as many alliance programs as possible in the next 12 months.

There are many ways to communicate: conversation, speech making, classroom lecture, telecommunications, etc. One of my favorite ways is story telling, so today I will tell you a story. It is a short story of my 30 years as a physician's spouse, but I have included some messages that may have meaning for you and this organization. I began my physician spouse experience when my husband, Woody, and I moved to San Diego, California, for his intern year in the Navy. I was invited to attend a "doctor's wives club" meeting and was thrilled to meet so many friendly people who all had so much in common. I knew I wanted to do my part and, before I knew it, I was the intern wives' representative. I learned about membership then and have been active and involved ever since. Remember the three I's — be inquisitive, stay informed and you will definitely be involved.

I found out along the way how important student loans were through the AMA-ERF, as Woody received one while he was a student. He needed additional financial support to continue his medical school education as the dependent of a single mother with a limited income. This student loan allowed for a very flexible pay back schedule at favorable interest rates. One of these loans paid all tuition, fees, room and board for Woody's junior year in medical school. AMA-ERF received over \$30,000 from South Carolina last year mostly due to our efforts, your efforts. The national total was over two million dollars — all raised by alliances across the country. The cost of medical education continues to go up so we must continue to increase our giving. It is also a gift, a legacy of physicians from one generation to another.

We all have our health projects and promotions throughout the state. For the Roper Mountain Science Center, the auxiliary in Greenville raised a substantial sum with their beautiful house tour. Home health care, the Red Cross, cancer research, mental health, children's hospitals, domestic violence centers, children's shelters and Hospice are but a few of the many recipients of our efforts across the state. They all need and depend on us for help. We must continue our efforts toward improving the health and health care of our communities. This year we are so pleased to join with the SCMA in their campaign against family violence. You will be hearing more about this later. You know, when called upon the alliance always responds! Childhood immunization and teenage pregnancy prevention are other areas of emphasis this year.

More than ever before, our legislative efforts are needed. Voter registration is of utmost importance as we try to get our message to our legislators. The AMA leadership is emphasizing the following reform efforts in 1995:

- Insurance reform to make sure that we do not lose coverage if we change jobs or get sick.
- Strong efforts to reform Medicare and reduce much of its red tape.
- Calling on America's physicians to reduce the level of care when it is unnecessary.
- Strong prevention efforts.
- Liability reform.
- Continue our patient protection efforts so we all have a choice. We all know that our spouses deliver the finest medical care in the world. Our spouses are dedicated, hard working professionals and we must do whatever we can to support and assist them and to support each other — for our role is truly unique.

Political activism is one of our greatest needs. Unfortunately, there are very few individuals who are willing to fill that need. Physicians in general do not have the time to involve themselves in political activity. I know that there are some of you who were raised in politically active families or have family members who have been in public office or in public service. I only ask you to consider that you may possess talent or expertise in the political arena that somehow is lying dormant or unused. If you do think that you could be of service in this area, please let someone know. Write your congressman, serve in voter registration drives and meet with your state, local and national legislators when possible. Let them know how you feel. Run for public office yourself.

Returning to my story, after we left the Navy in 1973, we returned to Charleston for one year of service on the faculty of MUSC. Other faculty wives were so friendly and kind to me, particularly Pam Griffin, Skippy Adkins and a beautiful lady known only as Mrs. Pettit. I also learned that the same AMA-ERF loan program Woody had used 10 years earlier had now grown and expanded many fold. Many of these loans were now being granted to female students, which pleased me a great deal. Upon moving to Spartanburg in 1974, I spent the next 13 wonderful years as a member of the Spartanburg County Medical Auxiliary. I served in various capacities over the years including president in 1981. Perhaps my favorite efforts were in the then annual rummage sale, our main fundraiser and, of course, the lovely tour of the beautiful home of my dear friend Julie Lowry. Upon moving to Union in 1987, I lived in my first truly small town. I soon came to know that in terms of medical auxiliary/alliance involvement, however, Union is large. Mary James is my friend, my partner, my assistant and my mentor. As you also know, Paul Doerner, the husband of Dr. Helen Stockinger, is the first male president of the county auxiliary/alliance in South Carolina. I have prepared for my year as president by serving on the state board for over 20 years.

Which brings me to now! We all have gifts to bring to the table. Now more than ever we need your time, talents and resources. Just when we are stretched to the maximum, we need to make all physicians' spouses aware of the importance of being a part and doing their part. I want to share with you a fable from Tolstoy —

The king called his wise men together to ask for the secret of life. The first one told the King that he would find it in the glory of the past! The second said he would find it in the wonders of the future, but the third was the wisest of all for he said the secret of life is now! My theme for this year is in this saying, "Yesterday is history," "Tomorrow is a mystery," "Today is a gift." That's why we call it the present! This has been a short history of my 30 years experience with physicians' spouse organizations and the many gifts I have received from them. I am sure many of you have similar stories to tell. All of these 30 years have really been a joy for me, but I want this 31st year to be the very best of all. I hope all of you and the entire membership can contribute something to help me reach that goal. Thank you all and God bless you.

Kiki Sanford (Mrs. H. Woodliff)
President, SCMA Alliance

If the U.S. Senate Can Deliver Health Care Liability Reform, Maureen O'Regan Can Deliver Babies Anywhere.



et Dr. Maureen O'Regan.
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deliver babies in Washington, but
the cost is too high and the risk is
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ALZHEIMER'S DISEASE IN SOUTH CAROLINA, 1994


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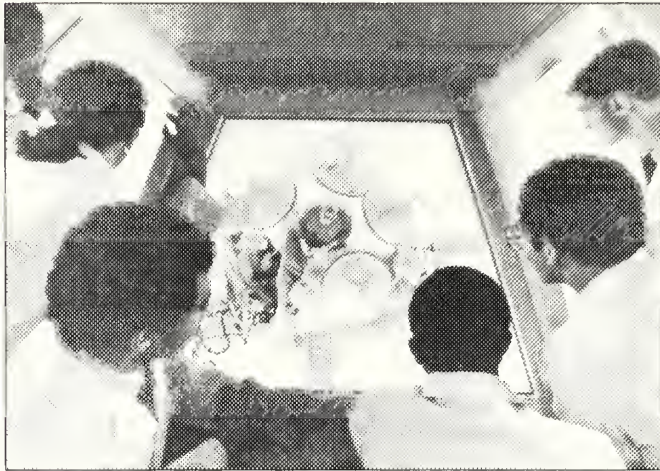


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President's Page

MANAGED CARE CONTRACTS


Recently I was asked to sign a contract with a major insurance company's managed care subsidiary. The contract contained a clause which stated that the company could terminate the contract without cause. I questioned the clause and was told that I was the only physician in the area who had questioned it. Negotiations with the company were unsuccessful largely because I was an individual physician and all other participating physicians had signed without protest.

Last month Blue Cross unilaterally amended its PPC agreement to include a clause (dubbed the "most favored nation" clause) which requires a physician to accept the lowest amount paid for a procedure by any other third party payor as payment in full.

These two examples of clauses in contracts have convinced me that:

1. We should all read our contracts very closely.
2. We should consult an experienced health care attorney if we are unsure of the implications of any part of a contract.
3. We should negotiate, if possible, through a group such as the local PHO.
4. We could ask the South Carolina Insurance Commission to review a clause, or clauses, which we have reason to believe may be illegal in South Carolina.

The SCMA last year published the *Physicians' Guide to Managed Care Contracts*. It contains valuable information which can help us understand contracts and negotiate with the companies offering them. I suggest reading it before signing your next contract.


Benjamin E. Nicholson, M. D.
President

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ALZHEIMER'S DISEASE IN SOUTH CAROLINA, 1994*

WILLIAM K. SCOTT, M. S. P. H.
YOUJIE HUANG, M. D., M. P. H.
CAROL CORNMAN, R. N., P. A.
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PAUL ELEAZER, M. D.
CAROLINE A. MACERA, PH.D.**

Dementia may be defined as the global impairment of intellectual and cognitive functions such as memory, abstract thinking, or judgement that seriously interferes with normal social and occupational activities.¹ The diagnosis of dementia includes Alzheimer's disease, multi-infarct (vascular) dementia, alcoholic dementia, Parkinson's disease with dementia, Huntington's disease, and other dementing illnesses. However, a definitive diagnosis of dementia is difficult, especially in the early stages.

Data for the registry are gathered by chart review. It is important to note that the registry staff are not directly involved in diagnosis;

rather, they record verbatim the physician's diagnosis from the patient's medical record. These diagnoses are coded using the International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM, 1980), and classified into four general categories for reporting purposes (Table 1).

The registry collects and maintains core data consisting of patient demographics and diagnostic data (using ICD-9-CM codes), caregiver contact data for follow-up of patients, and the place where the records were abstracted. The abstracting form also includes medical diagnoses, tests performed, scores on mini-mental state exams, educational status, and, when appropriate, date and cause of death. Illiteracy and mental retardation are noted if present. If there is a family history of dementia, it is also recorded. This abstract form contains all items recommended for a national core data set on dementia.

*From the Schools of Public Health (Mr. Scott, Dr. Huang and Macera, Ms. Cornman, Ms. Neff, Ms. Torres, and Mr. Otterness) and Medicine (Drs. Eleazer and Macera), University of South Carolina, Columbia.

**Address correspondence to Dr. Macera at the Alzheimer's Disease Registry, James F. Byrnes Center for Geriatric Medicine, Education, and Research, P.O. Box 119, Columbia, SC 29202

TABLE 1
CLASSIFICATION OF DEMENTIAS BY
ICD-9-CM CODES
Statewide Alzheimer's Disease and Related
Disorders Registry, 1994

ALZHEIMER'S DISEASE	
290.0-290.3	Senile or presenile dementia
290.8-290.9	
331.0	Alzheimer's disease
MULTI-INFARCT or VASCULAR DEMENTIA	
290.4-290.43	Arteriosclerotic dementia
ALCOHOL or DRUG-INDUCED DEMENTIA	
291.2	Alcohol dementia
292.82	Drug-induced dementia
MEDICAL DIAGNOSES WITH DEMENTIA	
294.1	Dementia with other conditions
310.10	Organic brain syndrome
331.1-331.9	Other cerebral degeneration
332.0-332.1	Parkinson's disease
333.4	Huntington's chorea
334.2-334.29	Primary cerebellar degeneration
334.9-334.99	Spinocerebellar disease

Because no single system in South Carolina identifies all newly diagnosed patients with dementia, new cases are collected primarily from monthly reports from the Department of Mental Health (including Community Mental Health Services) and Community Long-Term Care. Approximately 300 new or updated records are processed monthly. All data reported here, unless otherwise noted, refer to prevalent 1994 cases.

In 1994, the registry maintained information on 7,467 individuals in South Carolina with a diagnosis of Alzheimer's disease or a related dementia. Sixty-two percent had a diagnosis of Alzheimer's disease and an additional 16 percent had a diagnosis of dementia due to stroke. The rest were due to alcohol or drug-induced dementia (9%), and dementia secondary to other medical conditions (14%). Highlights of the 1994 registry data include:

- Fifty-nine percent of those living in the community have a diagnosis of Alzheimer's disease (Table 1).
- Those with Alzheimer's disease are most often diagnosed between the ages of 75 and

84.

- Thirty-eight percent of people with Alzheimer's disease are currently over 84 years of age.
- Seventy-seven percent of the people with Alzheimer's disease who reside in the community are currently over 74 years of age (Figure 2).
- Eighty-one percent of the people with Alzheimer's disease living in institutions are currently over 74 years of age (Figure 2).
- More women than men are affected with Alzheimer's disease and multi-infarct (vascular) dementia, possibly due to the larger proportion of women alive after age 65.
- African-Americans, who comprise nearly 30 percent of the adult South Carolina population, are over-represented in all dementia categories (over 40 percent in each category).
- Forty-nine percent of people with Alzheimer's disease who reside in the community are African-American (Figure 3).
- Approximately half the people with Alzheimer's disease have less than a high school education.
- Sixty-two percent of people with Alzheimer's disease are single, widowed, divorced, or separated (65 percent of those in institutions and 59 percent of those in the community (Figure 4).
- Summary information on the number of deaths between 1988 and 1994 indicates that about 40 percent of the dementia diagnoses are made within two years of death and about 25 percent of the dementia diagnoses not due to medical causes is diagnosed more than five years before death.
- The onset of symptoms occurs more than five years before death for almost half the dementia cases.

Considering the increasing numbers of affected persons, the lack of effective treatment, and the length of time that persons and their families require resources, Alzheimer's disease is likely to influence health care financing on a national level. Data collected by this registry can help South Carolina effectively plan for this emerging health problem.

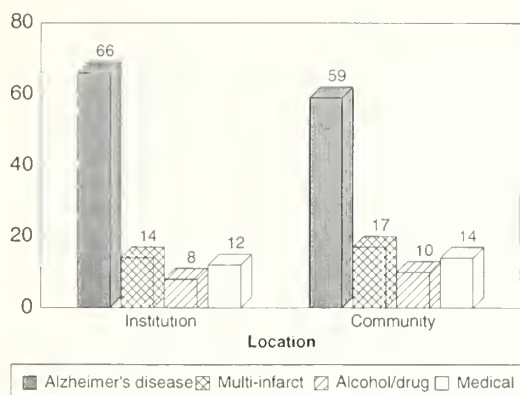


Figure 1. Percentage of Registry Cases by Dementia Type and Community or Institution Location.

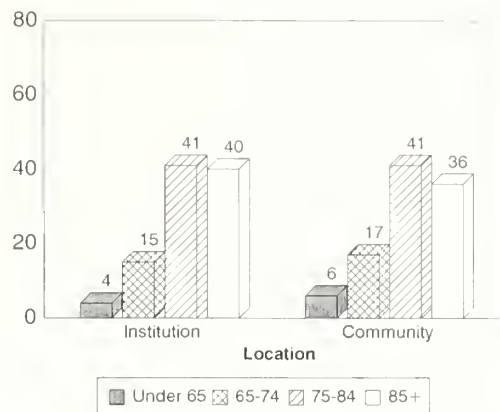


Figure 2. Percentage of Alzheimer's Disease Cases by Age and Community or Institution Location.

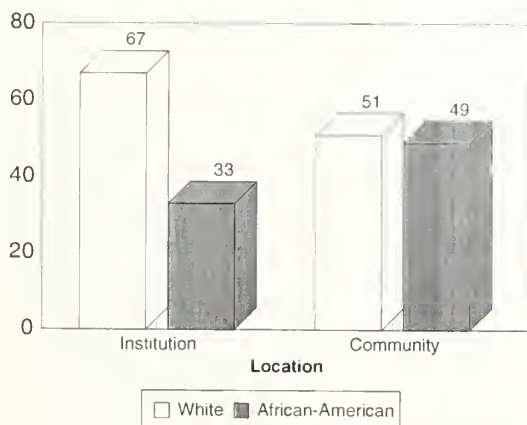


Figure 3. Percentage of Alzheimer's Disease Cases by Ethnicity and Community or Institution Location.

ACKNOWLEDGMENTS

The growth and development of the registry has been due to the combined effort of many individuals and organizations. We particularly want to acknowledge the contribution of the University of South Carolina (School of Public Health and School of Medicine) for core support, the SC Department of Mental Health for access to data and for providing space in the J. F. Byrnes Center for Geriatric Medicine, Education, and Research, the SC Health and Human Services Finance Commission for core support and access

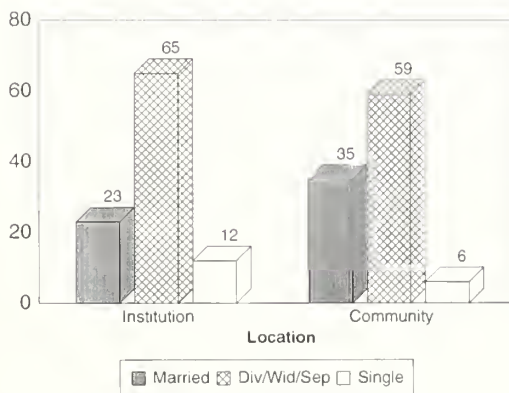


Figure 4. Percentage of Alzheimer's Disease Cases by Marital Status and Community or Institution Location.

to data, and the Office of the Governor, Division on Aging for their continued support. □

REFERENCES

1. Advisory Panel on Alzheimer's Disease. Fourth Report of the Advisory Panel on Alzheimer's Disease, 1992. NIH Pub. No. 93-3520. Washington, DC: Supt of Docs., U.S. Govt. Print. Off., 1993.
2. U. S. Department of Health and Human Services. The International Classification of Diseases, 9th revision. Clinical Modification, 2nd edition, (DHHS Publication No. PHS 80-1260), Public Health Service, Health Care Financing Administration. Washington, DC: U. S. Government Printing Office, 1980.

NUTRITIONAL SCREENING OF OLDER SOUTH CAROLINIANS: A PILOT STUDY*

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MARY BUNDRICK, M. A.

Adults aged 65 and older account for 12 percent of the population and this figure is expected to increase to 21 percent by the year 2030. In South Carolina there are more than 552,000 citizens over 60 years, representing 15 percent of the population.¹ Numerous studies have shown that older adults are vulnerable to malnutrition. There is increasing evidence that nutritional deficiencies increase morbidity as well as mortality and result in greater utilization of health care resources.² Malnutrition often goes unrecognized and undertreated in both ambulatory and inpatient care.³

In 1991 the Nutrition Screening Initiative (NSI) was formed as a direct response to the Surgeon General's workshop on health promotion and aging and the U.S. Department of Health and Human Services Report *Healthy People 2000*.⁴ The sponsoring agencies for NSI were the American Dietetic Association, the Academy of Family Physicians and the National Council on the Aging. The NSI believes that nutritional interventions for older adults must be interdisciplinary and the first step is a Checklist which can be completed by the older adult and can be self scored. The NSI can not be used to diagnose malnutrition, but rather it can be used to identify those elders with potential for nutrition related problems.⁵ A comprehensive nutritional assessment including: anthropometric measurements; blood analysis; history and physical and dietary evaluation should be complete on those individuals identified at high risk for nutritional

deficiencies. An algorithm was designed by the consensus panel to determine what needs to be done after the initial evaluation.⁶

METHODOLOGY

With leadership from the Office of the Governor's, Division on Aging, and the University of South Carolina School of Medicine, Division of Geriatrics, the South Carolina NSI Planning Committee was established. Their efforts resulted in a survey called "Eat Right Carolina" being conducted in Newberry county. Initially, the planning committee wanted to distribute the nutrition Checklist across the entire state. However, without outside funding, it was decided that a pilot project should be conducted in just one county. Newberry was selected because of its close proximity to the state agencies involved in the project. Newberry County was selected also because it has the highest percentage of residents over the age of 60, and the local Council on Aging was very supportive of the project. Committee members, Council on Aging personnel and volunteers distributed and collected the Nutrition Checklist for two months. The forms were made available to recipients of home delivered meals and other in-home services, participants at congregate meal sites, in grocery, drug and department stores, at the hospital, printed in the newspaper and were available at community events. No attempt was made to randomize the sample.

RESULTS

Four hundred two residents from Newberry county completed the Nutrition Checklist. This represents six percent of the county's population over 60 years of age. The average age of the participant was 70 years of age (Range 60-92). This included 88 percent Caucasian, nine

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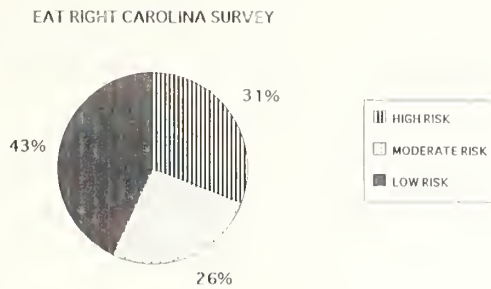


Figure 1.

percent African American and less than one percent were Hispanic. Eighteen percent were male and 72 percent female. Additionally, 44 percent lived alone while 66 percent lived with someone. Also, 46 percent were married, 44 percent widowed, six percent single and four percent had been divorced. Forms were obtained by the participants through numerous routes. Forty-three percent of the Nutrition Checklists were obtained at stores, 18 percent at senior centers, 15 percent from the newspaper, 14 percent at community events, the remaining 10 percent were obtained through health care providers.

The mean score on the checklist was 4.3, placing 124 participants at high risk and 104 participants at moderate risk for nutritional problems (See Figure 1). Other findings included the fact that 25 percent of the people reported incomes of \$580 or less per month and 17

percent reported that they did not always have money for food.

One hundred and forty-eight participants or 37 percent of the sample identified that an illness made them change the kind or amount of food they eat. One hundred and seventy-two people reported taking three or more medications per day. The responses to all of the questions on the Checklist are given in Figure 2.

DISCUSSION

Appropriate interventions need to be made available to the older adults who took the time to complete and return the Checklist. The results of the survey were shared with officials from numerous agencies in Newberry county. Social interventions were identified as fundamental to assisting older individuals with obtaining, preparing and eating an appropriate diet. Oral problems can profoundly affect an individual's food intake and additional dental services need to be available in the county. Mental health is also a factor in the ability of a person consuming an adequate diet. Changes in mental status, depression and loneliness all impact on nutrition. Medications affect the utilization of nutrients. Because polypharmacy is common in the older adults, a nutrient-drug screen through local pharmacists should be available to identify potential problems. Nutrition education and counseling for older adults can play a vital role in helping the older adults make appropriate therapeutic changes in their

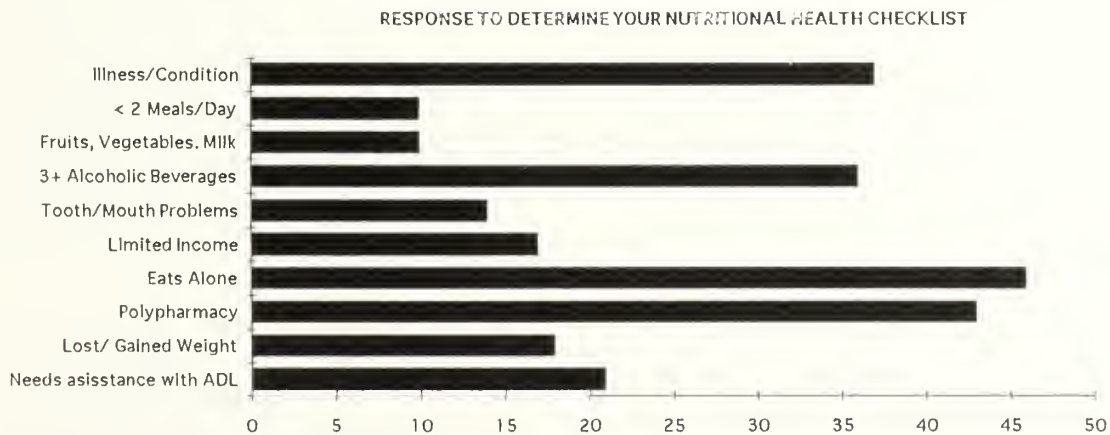


Figure 2.

diet. Comprehensive nutritional assessment should be available from physicians for those individuals who are at high risk for malnutrition. This service should be provided by a physician who is knowledgeable in assessment of dietary deficiencies. The Nutrition Checklist committee was also concerned that the forms did not reach older adults who do not read and write and to those who are confined to their homes. These findings are alarming in the light of the fact that better educated, more affluent and more mobile older adults in the county who took the screening were found to be at nutritional risk. What is the nutrition status of those not reached by the screening checklist?

SUMMARY

Malnutrition can be a major health care problem for older adults. Thirty-one percent of the participants in a pilot study, conducted in Newberry county, were determined to be at high risk for nutritional deficiencies and 26 percent were at moderate risk. All health care professionals who work with the elderly must become aware of the NSI and offer the Check-

list to their clients. The solutions to malnutrition require multidisciplinary interventions and the physician is the central figure in this team approach to improving the quality and quantity of life for older adults.

To obtain copies of the NSI write to: The Nutrition Screening Initiative, 2626 Pennsylvania Avenue, NW, Suite 301, Washington, DC 20037, or telephone: 202/ 625-1662. □

REFERENCES

1. A Profile of Older South Carolinians. South Carolina, Columbia, SC, Commission on Aging, 1990.
2. White, JV. Risk factors for poor nutritional status in older Americans; *American Family Physicians*; 44(6): 2087-2090, 1991.
3. Gunby, MC & Morley, JE. Malnutrition in older people. *Resident and Staff Physician*; 59-70, 1993.
4. Nutrition Screening Manual for Professional Caring for Older Americans. Washington, DC: Nutrition Screening Initiative; 1991.
5. Posner, BM, Jette, AM, & Smith, KW. Nutrition and health risks in the elderly: the Nutrition Screening Initiative. *American Journal of Public Health*; 83: 972-978, 1993.
6. White JV, Dwyer, JT, Posner, BM, Ham, RJ, Lipschitz, DA, Wellman, NS. Nutrition Screening Initiative: Development and implementation of the public awareness and screening tools. *Journal of the American Dietetics Association*; 92: 163-167, 1992.

NOCTURNAL BLOOD PRESSURE MEASUREMENT: CAN IT BE PREDICTED BY SELF-MONITORING AND IS 24-HR BP MONITORING CLINICALLY IMPORTANT IN THE TREATMENT OF HYPERTENSION?*

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The relationship between hypertension, even at mild levels and hypertension related end-organ damage is well established. Most of the studies that have looked at this relationship utilize clinic blood pressures. Over the past 10 years many reports relate 24-hour blood pressure levels to hypertension end-organ damage. Many of these studies have shown that 24-hour blood pressure levels are more important predictors of hypertension-related end organ damage than are clinic blood pressures.¹ In addition, clinic blood pressures may be artificially raised by the "white coat" effect.² In this situation a patient's blood pressure is 10-20 mmHg higher when in a clinic or physician's office compared to home-monitored BP results.

In addition to the relationship between 24-hour blood pressure levels and hypertensive end-organ damage, accumulating research has shown that other parts of the 24-hour blood pressure spectrum may predict hypertension-related end-organ damage. These components include the daytime level of blood pressure, the nighttime

level of blood pressure, and the difference between daytime and nighttime blood pressure level, i.e., circadian blood pressure variation.

Nocturnal sleep-associated blood pressures cannot be self-monitored. A 24-hour blood pressure monitor is needed for clinicians to detect abnormal circadian BP pattern. Recent studies suggest that abnormal circadian BP patterns ("nocturnal hypertension") may predict hypertension-related end-organ damage.³

Twenty-four-hour blood pressure monitoring is costly and inconvenient for the patient. One would like to be able to predict nighttime blood pressure by monitoring blood pressures prior to sleep and after awakening in the morning. In addition, one would like to assess the affect of sleep/wake intervals (which may be affected by the ambulatory BP monitor) on the 24-hour blood pressure pattern, and specifically on the nocturnal sleep-related blood pressures.

SELF-MONITORED BLOOD PRESSURE AND NOCTURNAL BLOOD PRESSURE

We attempted to answer some of these questions by studying 32 subjects including 26 patients with chronic renal failure and six control subjects. (We and others previously reported abnormal circadian blood pressure patterns in patients with chronic renal failure.⁴) All patients monitored their blood pressure at home

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for three sequential days prior to falling asleep and immediately after awakening in the morning. Next, the subject's blood pressure was monitored with a 24-hour blood pressure measuring device (SpaceLabs 90202 BP monitor). This BP monitor is rather noisy compared to the currently available SpaceLabs 90207 monitor. The 90202 monitor recorded patients systolic, diastolic, and mean arterial pressure, and heart rate every 20 minutes for 24 hours. After 24-hour monitoring, the patient filled out a sleep questionnaire to determine the time they fell asleep and woke up daily.

The self-monitored pre/post-sleep blood pressures did not change significantly prior to sleep or after awakening. Thus, we learned that self-monitored blood pressure in these patients was not predictive of their day/night blood pressure changes. We also discovered that evaluation of 24-hour blood pressure data must consider awake time at night, since blood pressure may rise during these intervals and give a false picture of the patient's circadian blood pressure profile.

"Dippers" versus "Non-Dippers"

Several subgroups may have abnormal circadian blood pressure patterns ("nocturnal hypertension"). These include diabetics, African-Americans, patients with: chronic renal failure; atherosclerotic cardiovascular disease; and autonomic dysfunction.⁵⁻⁸ Researchers have attempted to study the affect of circadian blood pressure on hypertensive end-organ damage by classifying patients according to the degree to which their blood pressure drops at night versus day values. In many published studies, subjects are arbitrarily defined as "dippers" if their nighttime mean blood pressures drop 10 percent or more compared to their daytime blood pressures.³ In our study when we used arbitrary cut-offs for defining patients as "dippers" or "non-dippers," adjustment for awake intervals during the night produced markedly different results. For example, even normal subjects who slept poorly during their 24-hour blood pressure monitoring had less than a 10 percent drop in nighttime versus daytime blood pressure

because of their awake time at night. When this awake time was excluded to calculate the day/night blood pressure change, these subjects demonstrated a normal nocturnal decline in blood pressure. For the 26 patients with chronic renal failure when we did not adjust the nocturnal awake intervals, and when we utilized a 10 percent drop in systolic BP to define normal "dipper," 23 subjects were classified as "non-dippers." When these awake intervals were excluded from the analysis, only 17 subjects were classified "non-dippers."*

Since prolonged nocturnal awake intervals may give erroneous "dipper"/"non-dipper" results, it may be more appropriate to look at the change in blood pressure comparing daytime to nighttime values as a continuous variable (percent change day/night) rather than a dichotomous variable ("dippers" versus "non-dippers"). This is consistent with many studies that show that clinic-related blood pressure levels correlate as a continuous variable to hypertension associated end-organ damage.

Will we use 24-hour and nighttime blood pressure data to make clinical treatment decisions in the future?

Research data is accumulating to show that hypertension-related morbidity, including proteinuria, exacerbation of renal insufficiency, left ventricular hypertrophy, and hypertension-related cardiovascular mortality may be predicted more accurately by 24-hour blood pressure parameters than by clinic blood pressures. If larger studies than those available to date confirm this notion, clinicians may use 24-hour blood pressure data more often in the future. In addition, 24-hour blood pressure monitoring will clearly have a use in discovering those 20 percent or more of the hypertensive population that have the "white coat" phenomenon, (hypertensive in the clinic, but normotensive when studied with 24-hour blood pressure monitoring). Twenty-four-hour monitoring is also essential to diagnose nocturnal hypertension

*Additional data and statistical tables are available from the authors upon request.

(abnormal circadian blood pressure pattern).

SUMMARY

We predict that 24-hour blood pressure data will be required prior to starting treatment in order to receive third-party payment. We are currently performing a cost benefit analysis in patients with mild to moderate hypertension to see the prevalence of inappropriate treatment of hypertension (diagnosed by normal 24-hour BP results) in an outpatient clinic population. We will compare the cost of treating that segment of the population that is inappropriately on treatment to the cost of 24-hour BP monitoring for the entire study population. As a result of this type of analysis, health care payors may require 24-hour BP documentation prior to hypertension treatment for all cases of mild to moderate hypertension. □

REFERENCES

1. Rizzoni D, Muiesan M, Montani G, et al: Relationship between initial cardiovascular structural changes and daytime and nighttime blood pressure monitoring. *Am J Hypertens* 5: 180, 1992.
2. Pearce K, Grimm R, Rao S, et al: Population-derived comparisons of ambulatory and office blood pressures. *Arch Intern Med* 152: 750-756, 1992.
3. Pickering TG: The clinical significance of diurnal BP variations - dippers and non-Dippers. *Circulation* 81: 700-702, 1990.
4. Rosansky S, Johnson K, Hutchinson C, Erdel S: Blood pressure changes during daytime sleep and comparison of daytime and nighttime sleep-related blood pressure changes in patients with chronic renal failure. *J Am Soc Nephrol* 4: 1172-1177, 1993.
5. Fogari R, Zoppi A, Domenico G, et al: Urinary albumin excretion of nocturnal blood pressure in hypertensive patients with Type II diabetes mellitus. *Am J Hypertens* 7: 808-813, 1994.
6. Harshfield G, Hwang C, Grim C: Circadian variation of blood pressure in blacks: influence of age, gender and activity. *J Human Hypertension* 4: 43-47, 1990.
7. Korbin I, Digman W, Kuman E, et al: Diurnal variation of blood pressure in elderly patients with essential hypertension. *J American Geriatric Society* 32: 896-899, 1984.
8. Mann S, Altman D, Raftery E, et al: Circadian variation of blood pressure in autonomic failure. *Circulation* 68(3): 477-483, 1983.

THE RESPONSE OF SOUTH CAROLINA PHYSICIANS TO THE DEMANDS OF WORLD WAR II*

EDWARD H. BOLAND, M. D.**

Although the U. S. would not enter World War II (WWII) officially until late 1941, military planners began opening lines of communication with SC physicians as early as the summer of 1939. In the June *Journal of the South Carolina Medical Association (The Journal)*, Dr. Edgar A. Hines, M. D., Secretary of the SCMA and Editor-in-Chief of *The Journal*, reported on a letter from the War Department that "the part the medical profession will continue to play in such emergencies depends largely upon the interest of the great civilian profession."² The interest displayed by the profession in South Carolina is, in retrospect, a story of personal sacrifice, compassion, exemplary leadership and strength of character.

At the annual meeting of the American Medical Association (AMA), held in New York in June of 1940, there was much discussion in reference to medical preparedness in the event of a national emergency.³ The AMA went so far as to appoint a National Preparedness Committee, and Dr. J. E. Paullin of Atlanta, GA, was appointed Chairman of the corps area that included South Carolina.⁴ Each state was asked to select a state chairman to serve as a liaison with the National Committee and to head a state Emergency Preparedness Committee (EPC). Dr. Hines accepted this task and immediately began assessing the status of all South Carolina physicians. He collected completed questionnaires which had been mailed to each physician by the AMA. Dr. W. L. Pressly of Due West, SC, President of the SCMA, urged

...each and every doctor in South Carolina to return his questionnaire to the American Medical Association office at once,.... I am

sure that each of you shares with me the desire that the South Carolina Medical Association shall do her full duty in this worthy endeavor. We have never failed in time of state of national emergency and we will not fail today.⁴

While some SCMA members were sluggish in answering their questionnaires, the zeal with which many physicians wanted to serve their country in uniform emerges from their questionnaire answers. For example, a Charleston physician complained "that I was unjustly thrown out for physical disability.... I am of the opinion that I am physically able to do more work than 50% of medical officers of any age."⁵ Regretfully, Dr. Hines did not live to see his work for the EPC come to fruition. After serving as Secretary of the SCMA for 30 years and as Editor of *The Journal* for almost as long, he died in November 1941. Dr. Pressly stepped into the leadership role of the EPC for the duration of the war, and Dr. Joseph I. Waring of Charleston assumed the duties of Editor-In-Chief of *The Journal*.

The bombing of Pearl Harbor, December 7, 1941, dashed any remaining hopes for staying out of the war. Preparations continued at a fevered pitch, including the development of numerous military facilities and hospitals throughout the state. The issue of which physicians would go into uniformed service and which would serve at home had to be settled. In December 1941, Dr. Julian P. Price reported that Presidential order had established "the Procurement and Assignment Service for Physicians, Dentists, and Veterinarians (PASPDV)" and that this new agency would "receive requests from various...agencies requiring professional personnel and to fill these needs through appropriate means. The entire program is predicated upon volunteering of service...."⁶ The PASPDV planned to make use of the data

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collected via the EPC questionnaires to meet the needs of both the armed forces and the civilian population as fairly as possible. A copy of the enrollment form for the PASPDV was also included in *The Journal*, and physicians were told:

By enrolling with the Procurement and Assignment Service immediately, all physicians, but particularly those under 45 years of age, insure to every extent possible assignment to the type of service for which they are best fitted. They avoid thus also the possibility of unclassified service with the United States Army....⁷

Each state formed a miniature Procurement and Assignment Service which answered to the parent PASVD in Washington, D.C. At the July, 1942 AMA Convention, Drs. Pressly, Price and Thomas Pitts attended a meeting of the National Procurement and Assignment Committee personnel. Dr. Price reported that "the general situation was presented and then suggested quotas were given to each state as to the number of physicians to be secured for military service for the remainder of this year." The success of South Carolina's effort was illuminated by Dr. Price's statement: "According to such unofficial figures as we could obtain South Carolina leads all states in the percentage of physicians in uniform,..." Indeed, by December of 1942, figures were available which demonstrated that South Carolina met 172 percent of its quota for physicians in service. However, Dr. Price also reported that

There are a few—a paltry few—who have left a black mark upon an otherwise clean escutcheon. They are all under 37 years of age, they have been declared 'available for military duty,' they have been offered commissions in the army of their own country—and they have refused to do aught but continue their daily work. To the call of duty, patriotism, love of country they have turned a deaf ear—and they continue on their selfish paths....It is our fervent hope—and this is stated without any feeling of spite or rancor—that these men will be waited upon by Selective Service, that they will be lifted from

civilian life and that they will be put in the ranks where they will be given a view of this country through the eyes of a marching private.⁸

At this time, Dr. Pressly and the PAS were able to focus on the home front: "The next and far more difficult task which faces Procurement and Assignment is that of attempting to supply the needs of various local communities with medical care."⁸ Several unsuccessful, informal attempts were made to maintain medical coverage in rural South Carolina. In August of 1943, Dr. W. A. Smith, President of SCMA, described a plan developed with the SCMA Council for assuring local coverage through a cooperative effort with the State Board of Health. Subsequent clarifications of this plan appear in *The Journal*, but the implementation and success or failure of the plan were not documented.

The SCMA attempted to help community physicians deal with some of their recurring problems during the war. In late 1942, large display posters and smaller cards entitled "How to Help Your Doctor," were offered for sale to the doctors by the SCMA. The cards, intended for distribution to patients, urged them "to help physicians carry this load" by making and keeping office appointments, limiting house calls and emergency calls, and being considerate of physicians in the context of strained circumstances.⁸

While the community doctors were concerned with maximizing the efficiency of their expanded practices, it is noteworthy that they did not intend to keep their new-found patients after the war.⁹ Organized medicine encouraged physicians to return such patients to their previous physicians when the latter came back from the war. Dr. J. R. Sosnowski relates that Dr. Henry DeSaussure, a Charleston obstetrician, finding it unconscionable to profit from the sacrifice of those in uniform, forwarded the payment he received to the patient's usual doctor or that doctor's family.¹⁰

Another issue physicians at home had to deal with was rationing. By the summer of 1942 there was a shortage of rubber for tires, and

gasoline was being rationed through the use of coupons. Dr. J. P. Price noted that "the needs of the physician are recognized as all important and his demands for the highest of priorities are granted." Price also reminded physicians not to abuse this privilege; rather "demands for gas and tires and new cars" should meet "both the letter and the spirit of the law." Practicing what he preached, Dr. Price traveled to the 1942 AMA meeting in Atlantic City, NJ, by bus:

Every physician who has ever advised—with nonchalance—his patient to come back to see him on the bus, ought to take such a ride. By the time we left Florence there was only standing room, and when we left Darlington even that was a premium. But they kept on packing them in and had passengers everywhere but on the radiator by the time we left Hartsville.⁸

In addition to shortages of gasoline and rubber, physicians were often forced to improvise or substitute due to lack of imported goods used in medicines, treatments and diagnosis.

While South Carolina's private physicians organized for war, academicians at the Medical College of the State of South Carolina (MCSSC) dealt with the increased demand for graduates and the decreased availability of instructors and supplies. By May of 1941, the Association of American Medical Colleges (AAMC) was urging schools to increase their enrollment and accelerate the graduation of already enrolled students. After the attack on Pearl Harbor, MCSSC initiated a 12-month academic year beginning with the 1942 entering class.¹² This practice continued until 1946. In 1940 and 1941, legislation passed increasing the freshman class size to 50 then 60 from the usual 42 to 44. Dr. Robert Wilson, Dean of MCSSC, was concerned about this plan because of the possibility of jeopardizing the school's accreditation, but reported his confidence that "some means will be adopted toward this end for the supply of physicians, both for the fighting forces and for the care of the civilian population...."¹³

By July 1943, quotas were in force at MCSSC directing that 55 percent of all gradu-

ates were future Army physicians, 25 percent Navy physicians and 20 percent would remain civilians. Dr. Wilson informed the faculty that "The Army and Navy has not, and probably will not, interfere with the class selections...these quotas will be filled by the Government if we cannot fill them. The Government is depending very much upon the colleges for selections."¹² The freedom of the admissions committee to choose students, and of the school to fill the military quotas was short-lived, for by September 1943, the government's "dependence" became a contractual obligation. Dr. Wilson told the Trustees that, "contracts with the Army and the Navy have been negotiated. That the military has not interfered with the college curriculum in anyway."¹⁴ The agreement reached between the MCSSC and the armed forces allowed for the initiation of the Army Specialized Training Program (ASTP) and the Navy's V-12 program on campus. Students were selected from three sources to receive medical training: (1) enlisted reserves (those students enrolled in premedical curriculums at approved colleges and universities, or already in medical school); (2) enlisted men in service; and (3) civilians. The ASTP and V-12 programs allowed for the enrollment of soldiers and sailors into abbreviated undergraduate premedical training programs and then medical school. Upon receipt of their medical degree, these graduates were commissioned in the Medical Corps of their branch of service and placed in inactive reserve status while they completed their internships. After nine months of internship, they were called to active duty.

Selection for the ASTP and V-12 programs became an issue when the armed forces decided to centralize control of their applicants. Regional selection boards, and not college admission committees, would determine who would attend medical schools in an active duty capacity starting with the class entering in 1945. Members of the MCSSC Board of Trustees were not pleased by this action, especially since "Northern boys through their system of schooling and testing are skilled in the

practice of standing examinations and tests, thus coming out on top, crowding our Southern boys aside."¹⁴ The Board of Trustees and the Governor continued to discuss ways of circumventing this process so that more South Carolinians could attend MCSSC; but, fortunately, the end of the war was not long in coming with victory over Japan in August of 1945, and the MCSSC admissions committee resumed their full duties without ever admitting an "entirely impersonal" class.

Conspicuously absent from this discussion is the active duty service of South Carolina physicians. News items published in *The Journal* throughout the war indicate that these men served with distinction. Regrettably, some South Carolina doctors spent time in prisoner of war camps, while others met their deaths in combat. The stories of South Carolina's military doctors, their innovations in dealing with shortages, their willingness to overcome obstacles, and their self-sacrifice in aiding their fellow soldiers and sailors are compelling, but require a separate forum to do them justice.

The response of South Carolina's physicians to World War II was remarkable. The early filling of South Carolina's quota of physicians in uniform was achievable only by the willingness of her physicians to volunteer for service. That South Carolina maintained medical coverage throughout the state is testament to the dedication of the remaining physicians to work longer and harder, with some coming out of retirement, and others relocating to needy areas. The guidance of South Carolina's medical leadership set the framework which allowed both the above issues to be resolved. This leadership was exceptional because there was no precedent upon which to draw during the massive mobilization. The integrity, character, and fortitude demonstrated during their period of great challenge sets a very high standard for present day physicians to follow. □

REFERENCES

1. A complete copy of the manuscript from which this article was condensed is available upon request from the Waring Historical Library, MUSC, 171 Ashley Avenue, Charleston, SC 29425.
2. E. A. Hines, M. D., "Report of the Secretary-Treasurer-Editor to the House of Delegates," *Journal of the South Carolina Medical Association (The Journal)*, 35 (June 1939), 150.
3. "The 1940 Session," *The Journal of the American Medical Association (JAMA)*, 114 (June 22, 1940), 2466-2467.
4. W. L. Pressly, M. D., "President's Page - Medical Preparedness," *The Journal*, 36 (August 1940), 227-228.
5. W. H. Price, M. D. Questionnaire Submitted to the A. M. A., on file at the Waring Historical Library, Medical University of South Carolina.
6. "P.A.S.P.D.V.," *The Journal*, 37 (December 1941), 331.
7. "A Call To The Medical Profession," *JAMA*, 117 (December 27, 1941), 2254-2255.
8. *The Journal* 38, (1942) 173-175; 323; 247; 324; 294; 171.
9. "Ohio's Nice Gesture," *The Journal*, 39 (February 1943), 47.
10. Interview with J. R. Sosnowski, M. D., Professor Emeritus of Obstetrics and Gynecology and Associate Dean Emeritus of the College of Medicine, Medical University of South Carolina, conducted by the author at the Medical University of South Carolina, January 10, 1994.
11. "Aid to National Defense," *JAAMC*, 16 (July 1941), 253.
12. Minutes of the Faculty of the Medical College of the State of South Carolina. Waring Historical Library, Medical University of South Carolina. Manuscript No. 352.
13. Report of the Medical College of the State of South Carolina 1941, p. 5. Archives of the Medical University of South Carolina.
14. Minutes of the Board of Trustees of the Medical College of the State of South Carolina. Waring Historical Library, Medical University of South Carolina; Manuscript No. 353.
15. Colonel Francis M. Fitts, M. C., U. S. Army, "Report on Training in Medicine and Pre-medicine Under the Army Specialized Training Program," speech given at the 54th Annual meeting of the Association of American Medical Colleges held in Cleveland, Ohio, October 25-27, 1943 and printed in *JAAMC*, 19 (January 1944), 15.

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SCMA NEWSLETTER

A PUBLICATION OF THE SOUTH CAROLINA MEDICAL ASSOCIATION
Joy Drennen, Editor
798-6207, in Columbia

Contributions welcomed
1-800-327-1021, outside Columbia

June 1995

HIGHLIGHTS OF MAY 24 BOARD OF TRUSTEES MEETINGS

Responding to the directive of the House of Delegates at its April 1995 meeting, the Board of Trustees was briefed by staff on possible actions concerning Blue Cross and Blue Shield of SC's attempt to insert a "most favored nation" clause into the PPC contract. The board discussed legal and administrative measures which could be taken at both the state and federal level.

The board was also briefed on the status of negotiations between SCMA and the SC Department of Highways and

Transportation concerning widening of the frontage road and relocation of the entrance ramps to highway I-26 immediately in front of SCMA Headquarters in Columbia.

The House of Delegates also directed SCMA staff to provide periodic updates on the status of managed care growth in South Carolina. Be sure to see information concerning managed care developments which appears on page 3. Such information items will appear in this newsletter periodically. ☐

MEDICARE UPDATE

The June, 1995 *Medicare Advisory* has been mailed. Please review this *Advisory* carefully.

Care Plan Oversight Services: HCFA recently clarified care plan oversight services as follows:

The patient's attending physician is expected to provide this service personally, and the "incident to" provisions do not apply to care plan oversight services. Nurse practitioners and physician assistants are precluded from billing for care plan oversight services. As such, only a doctor of medicine, osteopathy or podiatric medicine is qualified to perform the required care plan oversight services that are billed as CPT code 99375.

Direct involvement by a physician in performing care plan oversight services is required because of the level of medical judgement that is needed to deal with the type of home health or hospice patient who requires complex or multi-disciplinary care modalities.

Laser-Assisted Uvulopalatoplasty: Medicare has discovered that some providers are billing CPT codes 42145 (Palatopharyngoplasty) or 42160 (Destruction of lesion, palate or uvula) to report laser surgery to cure snoring or obstructive sleep apnea. This procedure is not medically necessary and should not be filed with these procedure codes. Claims filed for laser surgery to cure snoring or sleep apnea will be denied.

Stress Test and Echocardiography: Effective May 1, 1995, Medicare will allow a separate payment for CPT codes 93015-93018 (Cardiovascular stress test...) when filed with CPT code 93350 (Echocardiography, real time...). Medicare will continue to deny CPT codes 93000-93010 (Electrocardiogram...) and 99354-99360 (Prolonged physician service...& Physician standby service...) as included in the reimbursement for the echocardiography.

ICD-9 Update: Please remember to choose a five-digit code if one is available. Your claim may be denied if the diagnosis is not coded to the highest level specified. ☐

MEDICAID UPDATE

Ophthalmology Update: Effective June 1, 1995, routine ophthalmoscopy (direct or indirect) is a part of general and specific ophthalmologic services, whenever indicated. It should not be reported separately.

Extended ophthalmoscopy (92225, 92226) may be billed in addition to an ophthalmological exam or an E/M service procedure code. If medically necessary, this code may be billed one time, per eye, per date of service. Procedure codes 92283 and 92284 are non-covered effective June 1, 1995.

A bulletin will be forthcoming to reflect the codes which have been adjusted to comply with the 70 percent Medicaid rate of the Medicare fee schedule.

Out-of-state Services: With the summer season rapidly approaching, the Finance Commission would like to remind providers that out-of-state services (any services provided beyond the 25 mile radius of the South Carolina border), are non-covered unless they are performed on an emergency basis or are prior approved before the service is rendered. □

WORKSHOP CALENDAR

Appealing Unfair Payments



In this half-day program presented by Practice Performance Seminars, participants will review the reasons for inadequate payments from Medicare and insurance carriers, as well as the tactics you can use to increase your payments or successfully appeal a non-payment. (Member tuition: \$125.00)

Dates & Locations: August 16, 1995 – Columbia – Sheraton Hotel and Conference Center
Two sessions: 9:00 am – 12:00 noon or 1:30 pm – 4:30 pm

Effective Collection Strategies

In this one-day seminar presented by IC System, Inc., participants will learn how to collect professionally as a patient advocate, using techniques uniquely different from those employed by collection agencies and other third party collectors. Participants will learn how to establish a written collections policy and to maximize the effectiveness of your correspondence, as well as how to keep accounts from becoming delinquent in the first place. (Member tuition: \$150.00)

Dates & Locations: September 13, 1995 – Columbia – Sheraton Hotel & Conference Center

For more information about these or other workshops or to register, please call Ginny Comer, extension 253, 798-6207 in Columbia or 1-800-327-1021 statewide. □

PHYSICIANS CARE NETWORK UPDATE

Since the last PCN Update, the Greenville Hospital System, HealthSouth Rehabilitation Hospital in Florence, and McLeod Regional Medical Center in Florence have joined the network as new providers.

MANAGED CARE UPDATE

PENDING HMO LICENSES IN SC

- **Aetna Health Plans of the Carolinas** has filed for two South Carolina counties adjacent to Charlotte.
- **Coventry Corporation**, headquartered in Nashville, Tennessee expects to have its HMO operational before the end of 1995.
- **Kaiser** anticipates approval by mid-year to operate in York, Lancaster, Chester, and Cherokee counties.
- **Partners National Health Plan**, a Winston-Salem, North Carolina headquartered plan, filed for licensure in November 1994 to include a five-county area near Charlotte and an upstate area to include Rock Hill, Spartanburg, and Greenville. Partners expects to be operational this month or by July with an IPA style plan.
- **US Healthcare**, headquartered in Blue Bell, Pennsylvania, recently licensed in Georgia, has developed an HMO presence in the southeast.

PPO PRODUCT OFFERED FOR UNINSURED

American Medical Security began offering an insured PPO product in York County and two adjacent South Carolina counties in mid-February for previously uninsured individuals and employer groups. A steeply discounted fee structure was negotiated with Piedmont Hospital and area physicians. The product, named Access to Health Care, is offered through the MedCost Preferred PPO in South Carolina.

SOUTH CAROLINA HOSPITAL NETWORKS

Carolina Health Choice Network contracted with Blue Cross Blue Shield of SC in spring 1994 to be part of the Blue Choice product, a network option with the broader Preferred Personal Care PPO network. With the addition of Clarendon County Hospital and The Regional Medical Center of Orangeburg, Carolina Health Choice has grown to nine hospitals. One of their hospitals, Richland Memorial, has begun acquiring primary care physician practices. Four practices involving 12 physicians have been secured as of late March.

Premier Health System, a for-profit 50-50 joint venture of Baptist and Providence Hospitals, now has eight participating hospitals and 555 contracted physicians and is beginning to market a PPO product. Premier is expected to contract with additional hospitals to create a statewide system.

(Excerpts reprinted with permission from Carolina Managed Care)

PUBLICATIONS/VIDEOTAPES AVAILABLE

The Alzheimer's Disease Education and Referral Center has announced the availability of a publication, "Alzheimer's Disease and Related Dementias: Legal Issues in Care and Treatment, 1994." This special report to Congress focuses attention on legal issues affecting people with Alzheimer's disease, their families, health care professionals and society. This report contains public policy recommendations for resolving problems in legal competency judgments in cases of probable Alzheimer's disease and other related dementias.

For a free copy of this publication, call Fran Gillen at 800-438-4380.

The SCMA Risk Management Committee has a new videotape available on loan, "Risk Factors in Medical Practice: Office Staff Communications." This AMA pub-

lication was designed to help physicians evaluate and improve their interactions with patients, other physicians and other staff members.

To borrow this videotape and an accompanying workbook, call Joy Drennen at extension 233, 1-800-327-1021 statewide or 798-6207 in Columbia.

Also, still available are copies of the SCMA Risk Management Committee videotape entitled, "Patients are People, Too." This videotape was produced at Spartanburg Regional Medical Center and is narrated by Spartanburg physician, William James, MD. Two versions, one in a clinic setting, and one in an office setting, are on hand. *To borrow a tape, call Joy Drennen at the number above and ask for the version you prefer.* ☐

1996 ANNUAL MEETING

SCMA staff is already receiving inquiries regarding the dates of the 1996 Annual Meeting. For your information, it will be held again in Charleston at the Omni Hotel, April 25-28.

Reserve these dates now.

CLIA REMINDER

Ways and Means Chair Bill Archer has introduced H.R. 1386 on behalf of MGMA, AMA and several medical specialty societies. The legislation would largely exempt physician offices from CLIA regulation. Please write your elected officials today in support of this bill. Please copy Congressman Archer on all of your correspondence: *Bill Archer, Chair, House Ways and Means Committee, Longworth House Office Building, Room 1102, Washington, DC 20515.* Write on behalf of your group and have individual members of your group write as well. A strong display of support is very important.

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Editorials

PRINCIPLE-CENTERED CHANGE

Nothing is permanent but change.

— Heraclitus (circa 500 B.C.)

These are my politics: to change what we can; to better what we can; but still to bear in mind that man is but a devil weakly fettered by some generous beliefs and impositions. . .

— Robert Louis Stevenson (1885)

Change is the law of life. And those who look only to the past or the present are certain to miss the future.

— John F. Kennedy (1963)

This year's Annual Meeting seemed to be characterized by calmness, good feelings, and a sense of unity in the medical profession. However, we heard that when managed care comes to South Carolina in full force, it is likely to sweep the state like a tornado. We heard murmurs about a possible physician surplus. We heard that "physicians have never learned that when it comes time to draw the wagons, you are supposed to shoot out." Yet we heard that the medical profession will indeed survive because of our ethics and professionalism.

Although change is indisputably the law of life, it has been said that the only people who welcome it are babies with wet diapers. Change rips us from our comfort zones. Change is threatening, stressful. All change is loss, forcing us to go through a grief cycle (or crisis/transition sequence). The four steps are as follows:

- *Impact:* We are in shock, and do not know whether to fight or flee. We are numb, disoriented, searching for something lost. We pine for "the good old days."
- *Recoil:* We are angry and depressed. Our self-esteem is severely threatened, and we may feel shamed or guilty. We do not know which way to turn. We feel detached from our environment. We scan the horizon, perplexed.
- *Adjustment:* We begin to accept the

inevitable. We clear our minds, searching for new structures. Our ability to focus begins to return.

- *Reconstruction:* We are now engaged in active, goal-directed problem-solving. Small successes restore our damaged self-esteem. We acquire new abilities. We begin to reattach to our surroundings, testing the new environment.

Our most important challenge, I believe, is that we must work through these steps *collectively* rather than individually to the greatest possible extent. For the new threats to our identity are sure to test (if they have not already tested) whether we truly are a unified profession capable of giving top priority to the public interest.

James O'Toole, in his recent book, *Leading Change*, argues that change is best led by those who consistently combine principles with pragmatism.¹ He submits that the common denominator of the four presidents whose heads are carved into Mt. Rushmore (Washington, Jefferson, Lincoln, and Theodore Roosevelt) was *values-based leadership*. They were men of character. Yet what is this commodity that we call "character?" My survey of the literature on this and related subjects leads me to conclude that the essence of character is having goals and actions firmly rooted in benevolent principles. Saying one thing and doing another never

reflects character. Submitting aimlessly to the prevailing winds never reflects character. Although it perhaps arguable whether character can be taught, I believe that the best prescription is threefold: (1) to have written principles that are consistent with society's highest values and priorities; (2) to have written goals that are entirely consistent with these principles; and (3) to give top priority to those actions that will move us closer to these goals. Character, in short, is congruity (Figure).

In these uncertain times, we should therefore search for high principles and worthy goals. Our principles are hardly secret; you'll find them at just about any forum sponsored by organized medicine. Like others, I was deeply impressed by this remark in Dr. Stoney Abercrombie's non-denominational worship service at this year's Annual Meeting: "If a doctor's life is not a divine vocation, then no life is a vocation and nothing is divine." Our goals should be determined through active participation and dialoguc. Dr. Donald Berwick, president and chief executive officer of the Institute for Healthcare Improvement, recently proposed five ways by which we might improve medicine of which the last was that we should *compete against disease, not against each other*:

The enemy is disease. The competition that matters is against ill health. The purpose is healing. On my drive to work I see billboard after billboard with silly rhymes urging me to join one HMO or another.... Every dollar of it is wasted.... I propose that we aim where it matters. Pressure sores are the enemy. Stop them. Errors in drug use are the enemy. Stop

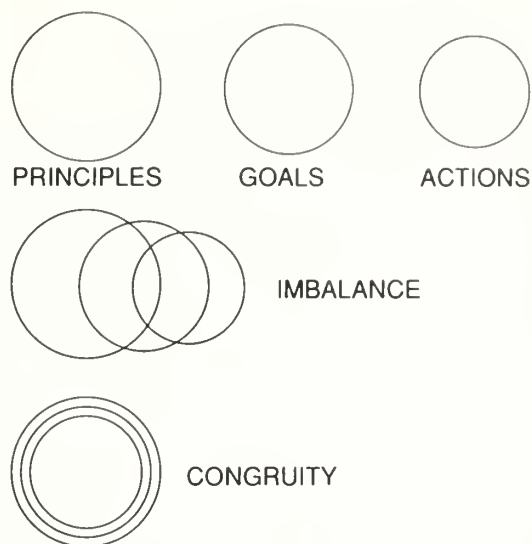


Figure. Character as congruity between principles, actions, and goals (see text).

them. Fragmentation is the enemy.... Stop it. If we cannot work together on improvements that matter to the people who call upon us for help, then I reject your restructuring, I dismiss your mergers, I doubt your integrated system.... I have heard it said by cynics that the quality of health care would be far better and the hazards far less if doctors, like pilots, were passengers in their own airplanes. We are.²

In change, there is opportunity. Let us therefore work together!

—CSB

REFERENCES

1. O'Toole J: Values-based Leadership (San Francisco: Jossey-Bass, Inc., 1995).
2. Berwick D: Quality comes Home. Quality Connection 4:1-4, Winter, 1995.

Guest editorials reflect the opinions of the authors and do not necessarily represent the opinions of the officers and trustees of the South Carolina Medical Association.

—CSB

ADOLESCENT VARIOCOCELE: CAREFUL EXAMINATION CONSIDERATIONS

The 15 percent incidence of adult varicocele in the general male population, and its potential influence on fertility and semen quality is rather common knowledge. A recent summation of the larger series in the world literature shows a mean percent of 16.2 percent in 21,878 boys from ages 10 to 25.

At the annual meeting of the Society of Pediatric Urology in San Francisco in 1994, which I attended, a symposium on the adolescent varicocele was presented. The conclusions were that the adolescent varicocele can be very significant and, in certain cases, worthy of correction in order to try to preserve maximum fertility.

This time of year, many physical examinations on boys will be performed for camp, school and athletic participation. As those physicals are accomplished, it is my

plea that those performing the exam keep a high index of suspicion for the left-sided varicocele.

The varicocele presents as a rather typical "bag of worms" in the left scrotal compartment. If a varicocele is present, the left testis soft rather than firm, and if the left testis is 1-2 cm smaller than the right testis, referral to a urologist would be indicated. If confirmed, the urologist will most likely order ultrasound volume measurement of the testes. A 2 cm³ difference is significant and should serve as the minimal requirement for surgical repair of the varicocele.

Fletcher C. Derrick, Jr., M. D., F. A. C. S.
1565 Sam Rittenberg Blvd.
Charleston, SC 29407

PHYSICIAN RECOGNITION AWARDS

The following SCMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned.

William J. Bannen, M. D.
Naseeb B. Baroodi, M. D.
Walter B. Blum, M. D.
Howard R. Bromley, M. D.
William C. Campbell, M. D.
Cindy S. Dieringer, M. D.
Terry L. Dodge, M. D.
Roy J. Ellison, M. D.
Hoke F. Henderson, M. D.
Charles W. Hinnant, M. D.
Jack F. Johnson, M. D.
Raymond Kaplan, M. D.

Michael J. Malone, M. D.
Baxter F. McLendon, M. D.
Satish M. Prabhu, M. D.
Lee J. Saindon, M. D.
Robert G. Schwartz, M. D.
Gregory E. Smith, M. D.
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On the Cover:

KENNETH MERRILL LYNCH, M. D., 1887-1974 PRESIDENT, SCMA, 1931

Kenneth Lynch was born on November 27, 1887, and reared on a cattle ranch in Hamilton County, Texas. He received his education in his native state, earning his M. D. degree from the University of Texas in 1910. After further training in Philadelphia, Dr. Lynch was called to be the first full-time faculty member of the newly restructured Medical College of the State of South Carolina. He began his tenure in 1913 as Professor of Pathology. Except for a five-year period of practice in Texas, he devoted the remainder of his life to the Medical College, serving as Vice Dean, Dean, and President, retiring in 1960 with the title of Professor Emeritus of Pathology and Chancellor.

Dr. Lynch was an active researcher even before the days of large research grants, publishing more than 118 papers in medical and scientific journals. He was a pioneer investigator of industrial diseases of the chest, particularly asbestosis. With W. Atmar Smith, he published the first recorded case of cancer of the lung associated with asbestosis.

In South Carolina Dr. Lynch is perhaps best remembered for his "master plan of expansion"

at the medical school—"launching the Medical College into the 20th century, transforming medical education in South Carolina from a proprietary, inbred, provincial system of schooling into a regional medical center whose influence would spread beyond the borders of South Carolina." The master plan encompassed many areas: reorganization and increase of full-time faculty, revision of curricula, establishing schools of dentistry and graduate studies, and the construction of numerous buildings on campus. The most visible and perhaps the most far reaching accomplishment was the opening in 1955 of the Medical College Hospital.

In his personal life, Lynch was an ardent hunter, an avid gardener, a gracious host, and a breeder of wild turkeys. It is said that "...he could charm a rattlesnake out of a tree."

Dr. Lynch died November 29, 1974, two days after his 87th birthday, "thus ending the career of one of the most influential medical educators in the Southeast of this century."

Betty Newsom
The Waring Historical Library



Continuing Medical Education

Third Quarter
1995
Calendar

James L. Haynes, M. D., Chairman

Published by the SCMA Committee on Continuing Medical Education
Post Office Box 11188, Columbia, SC 29211

Note: CME activities in neighboring states are listed when space permits.

JULY

Monday-Saturday **July 3-8, 1995**
Myrtle Beach, SC, Kingston Plantation Radisson
Resort

Mid-Summer Family Practice Digest
SPONSOR: SC Academy of Family Physicians
CONTACT: Diane Gajowski, (803) 781-6467
CME CREDITS: 34 AAFP Prescribed Hours

Wednesday **July 5, 1995**
Columbia, SC, James F. Byrnes Center for Geriatric
Medicine, Education and Research
Research Conference

SPONSOR: James F. Byrnes Center for Geriatric Medi-
cine, Education and Research
CONTACT: JoAnn Watts, (803) 734-0812
FACULTY: Carlton A. Hornung, PhD, MPH
CME CREDITS: 1 Hour, AMA Category 1

Monday-Wednesday **July 10-12, 1995**
Sea Island, GA
15th Annual Update in Gynecology

SPONSOR: Medical College of Georgia School of
Medicine
CONTACT: Katrinka Akeson, (706) 721-3967
CME CREDITS: 16 Hours, AMA Category 1; 16 Cog-
nates by ACOG

Wednesday **July 12, 1995**
Columbia, SC, James F. Byrnes Center for Geriatric
Medicine, Education and Research
Grand Rounds - Anemia in the Elderly

SPONSOR: James F. Byrnes Center for Geriatric Medi-
cine, Education and Research
CONTACT: JoAnn Watts, (803) 734-0812
FACULTY: Rosemary Lambert-Falls, MD
CME CREDITS: 1 Hour, AMA Category 1

Wednesday-Friday **July 12-14, 1995**
Sea Island, GA

15th Annual Clinical Obstetrics
SPONSOR: Medical College of Georgia School of
Medicine
CONTACT: Katrinka Akeson, (706) 721-3967
CME CREDITS: 16 Hours, AMA Category 1; 16 Cog-
nates by ACOG

Wednesday-Saturday **July 12-15, 1995**
Hilton Head Island, SC, Sea Pines Resort Conference
Center

Internal Medicine Update
SPONSOR: SC Academy of Family Physicians
CONTACT: George M. Converse, MD, (205) 783-5276
CME CREDITS: 17.25 AAFP Prescribed Hours

Saturday-Sunday **July 15-16, 1995**
Columbia, SC, National Guard Armory
Advance Life Support in Obstetrics
SPONSOR: SC Academy of Family Physicians
CONTACT: Sandi Owens, (803) 227-4869
CME CREDITS: 12.5 AAFP Prescribed Hours

Thursday-Saturday **July 20-22, 1995**
Myrtle Beach, SC, Myrtle Beach Hilton
SCAFP Family Practice Weekend
SPONSOR: SC Academy of Family Physicians
CONTACT: Paquita P. Turner, (803) 984-7237
CME CREDITS: 12 AAFP Prescribed Hours

Monday-Wednesday **July 24-26, 1995**
St. Simons Island, GA
18th Annual Pediatric Update
SPONSOR: Medical College of Georgia School of
Medicine
CONTACT: Katrinka Akeson, (706) 721-3967
CME CREDITS: 14 Hours, AMA Category 1

Monday-Wednesday **July 24-26, 1995**

Sea Island, GA

General Surgery Update

SPONSOR: Southern Medical Association

CONTACT: 1-800-423-4992

Monday-Thursday **July 24-27, 1995**

Kiawah Island, SC, Kiawah Island Resort

Focus on the Female Patient

SPONSOR: SC Academy of Family Physicians

CONTACT: Shelia Gonseth, (803) 945-1840

CME CREDITS: 18 AAFP Prescribed Hours

Wednesday **July 26, 1995**

Columbia, SC, James F. Byrnes Center for Geriatric
Medicine, Education and Research

Journal Club

SPONSOR: James F. Byrnes Center for Geriatric Medi-
cine, Education and Research

CONTACT: JoAnn Watts, (803) 734-0812

CME CREDITS: 1 Hour, AMA Category 1

Friday-Sunday **July 28-30, 1995**

Kiawah Island, SC, Kiawah Island Resort

Focus on the Male Patient

SPONSOR: SC Academy of Family Physicians

CONTACT: Michelle Williamson, (803) 945-1840

CME CREDITS: 13 AAFP Prescribed Hours

Friday-Sunday **July 28-30, 1995**

Jeckyll Island, GA

Gastroenterology Update

SPONSOR: Southern Medical Association

CONTACT: 1-800-423-4992

Monday-Wednesday **July 31-August 2, 1995**

Sea Island, GA

ENT for Primary Care

SPONSOR: Southern Medical Association

CONTACT: 1-800-423-4992

Monday-Friday **July 31-August 4, 1995**

Columbia, SC, Richland Memorial Hospital

Primary Training in Hyperbaric Medicine

SPONSOR: USC School of Medicine

DESCRIPTION: A comprehensive introduction to the
role of hyperbaric oxygen therapy in modern medical
practice.

TYPE OF AUDIENCE: Physicians, therapists, technolo-
gists, and nurses involved in hyperbaric oxygen therapy

CONTACT: Susan Pearson, (803) 434-4211

FAX: 434-4288

PROGRAM FEE: \$650 for physicians and dentists

FACULTY: Dick Clarke and Robert L. Bartlett, MD

CME CREDITS: 40 Hours, AMA Category 1

AUGUST

Wednesday **August 2, 1995**

Columbia, SC, James F. Byrnes Center for Geriatric
Medicine, Education and Research

Research Conference

SPONSOR: James F. Byrnes Center for Geriatric Medi-
cine, Education and Research

CONTACT: JoAnn Watts, (803) 734-0812

FACULTY: Carlton A. Hornung, PhD, MPH

CME CREDITS: 1 Hour, AMA Category 1

Thursday-Sunday **August 3-6, 1995**

Litchfield by the Sea, SC

Primary Care 1995

SPONSOR: SC Academy of Family Physicians

CONTACT: Nan Major, (803) 327-4502

CME CREDITS: 16.25 Prescribed Hours

Friday-Sunday **August 4-6, 1995**

Sea Island, GA

Pediatric & Adolescent Medicine

SPONSOR: Southern Medical Association

CONTACT: 1-800-423-4992

Wednesday **August 9, 1995**

Columbia, SC, James F. Byrnes Center for Geriatric
Medicine, Education and Research

Grand Rounds - Chronic Pain Management

SPONSOR: James F. Byrnes Center for Geriatric Medi-
cine, Education and Research

CONTACT: JoAnn Watts, (803) 734-0812

FACULTY: Iva Chappell, MD

CME CREDITS: 1 Hour, AMA Category 1

Thursday-Saturday **August 10-12, 1995**

Sea Island, GA

Neurology for the Non-Neurologist

SPONSOR: Medical College of Georgia School of
Medicine

CONTACT: Katrinka Akeson, (706) 721-3967

CME CREDITS: 15 Hours, AMA Category 1

Saturday **August 12, 1995**

Atlanta, GA, Scottish Rite Children's Medical Center

Pediatric Tools of the Trade

CONTACT: Jane Darrish, M.S.N., (404) 250-2937

PROGRAM FEE: \$75 for physicians, \$45 other allied
health professionals

CME CREDITS: 4 Hours

Sunday-Friday **August 13-18, 1995**

Sea Island, GA

17th Annual Critical Care Medicine

SPONSOR: Medical College of Georgia School of Medicine
CONTACT: Katrinka Akeson, (706) 721-3967
CME Credits: 22 Hours, AMA Category 1

Tuesday-Wednesday August 19-23, 1995
Atlanta, GA
Step Disorders

SPONSOR: Medical College of Georgia School of Medicine
CONTACT: Katrinka Akeson, (706) 721-3967
CME Credits: 25 Hours, AMA Category 1

Wednesday August 23, 1995
Columbia, SC, James F. Byrnes Center for Geriatric Medicine, Education and Research
Journal Club

SPONSOR: James F. Byrnes Center for Geriatric Medicine, Education and Research
CONTACT: JoAnn Watts, (803) 734-0812
FACULTY: John Egbert, MD
CME CREDITS: 1 Hour, AMA Category 1

Sunday-Thursday August 27-31, 1995
Charleston, SC, Omni Hotel
First to First in Cardiovascular Health - 2nd Annual Meeting of the Consortium of Southeastern Hypertension Centers

SPONSOR: Medical University of South Carolina
DESCRIPTION: This course is designed to identify factors underlying the high incidence of cardiovascular mortality in the Southeast and the potential solutions to this serious regional health problem.
TYPE OF AUDIENCE: Primary care physicians
CONTACT: Odessa Ussery, (803) 792-4071
PROGRAM FEE: \$100 for COSEHC meeting; \$50 for satellite conference on August 27
FACULTY: Guest faculty and MUSC faculty
CME CREDITS: up to 30 Hours, AMA Category 1

SEPTEMBER

Wednesday September 6, 1995
Columbia, SC, James F. Byrnes Center for Geriatric Medicine, Education and Research
Research Conference

SPONSOR: James F. Byrnes Center for Geriatric Medicine, Education and Research
CONTACT: JoAnn Watts, (803) 734-0812
FACULTY: Carlton A. Hornung, PhD, MPH
CME CREDITS: 1 Hour, AMA Category 1

Tuesday-Saturday September 12-16, 1995
Mt. Pleasant, SC, Holiday Inn
Sexual Assault Examiner Training Course
SPONSOR: Medical University of South Carolina
TYPE OF AUDIENCE: Primary care physicians
CONTACT: Odessa Ussery, (803) 792-4071
PROGRAM FEE: TBA
FACULTY: Guest faculty and MUSC faculty
CME CREDITS: 40 Hours, AMA Category 1

Wednesday September 13, 1995
Columbia, SC, James F. Byrnes Center for Geriatric Medicine, Education and Research
Grand Rounds - Depression in the Elderly
SPONSOR: James F. Byrnes Center for Geriatric Medicine, Education and Research
CONTACT: JoAnn Watts, (803) 734-0812
FACULTY: Lynn Hackett, MD
CME CREDITS: 1 Hour, AMA Category 1

Saturday September 16, 1995
Columbia, SC, Embassy Suites
5th Annual Cardiology Symposium
SPONSOR: USC School of Medicine
DESCRIPTION: An update on the advances in the diagnosis and treatment of cardiovascular disease.
TYPE OF AUDIENCE: Physicians involved in the daily care of patients with cardiovascular disease.
CONTACT: Susan Pearson, (803) 434-4211
FAX: 434-4288
PROGRAM FEE: None
FACULTY: Barry J. Feldman, MD; Charlie Dom Smith, MD
CME CREDITS: 6 Hours, AMA Category 1

Wednesday-Friday September 20-22, 1995
Augusta, GA
19th Annual Neonatology - The Sick Newborn
SPONSOR: Medical College of Georgia School of Medicine
CONTACT: Katrinka Akeson, (706) 721-3967
CME CREDITS: 16 Hours, AMA Category 1

TBA
Augusta, GA
Advanced Trauma Life Support
SPONSOR: Medical College of Georgia School of Medicine
CONTACT: Katrinka Akeson, (706) 721-3967
CME CREDITS: 17 Hours, AMA Category 1

Tuesday-Saturday September 22-23, 1995
Clemson, SC, Ramada Inn
Clemson/MUSC Sym-PAWS-ium '95
SPONSOR: Medical University of South Carolina

DESCRIPTION: This course is designed as an update in the areas of pediatrics, cardiology, dermatology, surgery, and sports medicine for the practicing physician.

TYPE OF AUDIENCE: All physicians

CONTACT: Odessa Ussery, (803) 792-4071

PROGRAM FEE: TBA

FACULTY: Guest faculty and MUSC faculty

CME CREDITS: TBA

Tuesday-Saturday **September 26-30, 1995**
Charleston, SC, Omni Hotel

4th Intensive Review of Emergency Medicine

SPONSOR: Medical University of South Carolina

DESCRIPTION: This course is an intensive review of the core content of emergency medicine as defined by the American College of Emergency Physicians and the American Board of Emergency Medicine.

TYPE OF AUDIENCE: Emergency physicians, family physicians, and internists

CONTACT: Odessa Ussery, (803) 792-4071

PROGRAM FEE: \$625 practicing physicians, \$300 physicians in training

FACULTY: Guest faculty and MUSC faculty

CME CREDITS: 40 Hours, AMA Category 1

Wednesday **September 27, 1995**
Columbia, SC, James F. Byrnes Center for Geriatric Medicine, Education and Research
Journal Club

SPONSOR: James F. Byrnes Center for Geriatric Medicine, Education and Research

CONTACT: JoAnn Watts, (803) 734-0812

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Alliance Page

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On April 23, 1995, the SCMA Alliance and SCIMER Scholarship Committee had the pleasure of presenting fourteen (14) \$1,200 scholarships to students from the Medical University of South Carolina (MUSC) and the University of South Carolina School of Medicine (USCSM).

The recipients are chosen by an interview process conducted by the Scholarship Committee in Columbia and Charleston, and are determined by need, academics, extracurricular involvement and interpersonal skills. This proves to be a somewhat difficult task in that each student interviewed was outstanding and deserving.

MUSC students presented scholarships were:

James Knoer
Chris Ratchford
Jennifer Anderson
Kimberly Martin
April Odom
Kristan Adams
James Hudson

USCSM students were:

Laura Basile
Joseph H. Chewning
Darby K. Hiller
Boykin Robinson
Valerie Skinner
Brett J. Cargill
Michael Ribadeneyra

Other scholarships given were:

Paul Richardson, MUSC - Conway Hospital Medical Staff Scholarship (\$1,000)
William B. Painter, USCSM; Cara E. Hahs, USCSM; and Jennifer Adams, MUSC - Spartanburg
Cardiovascular Consultants Scholarship (\$1,000 each)
Richard Taylor Williams, MUSC - Annie Fair Scholarship (Greenville) (\$1,000)
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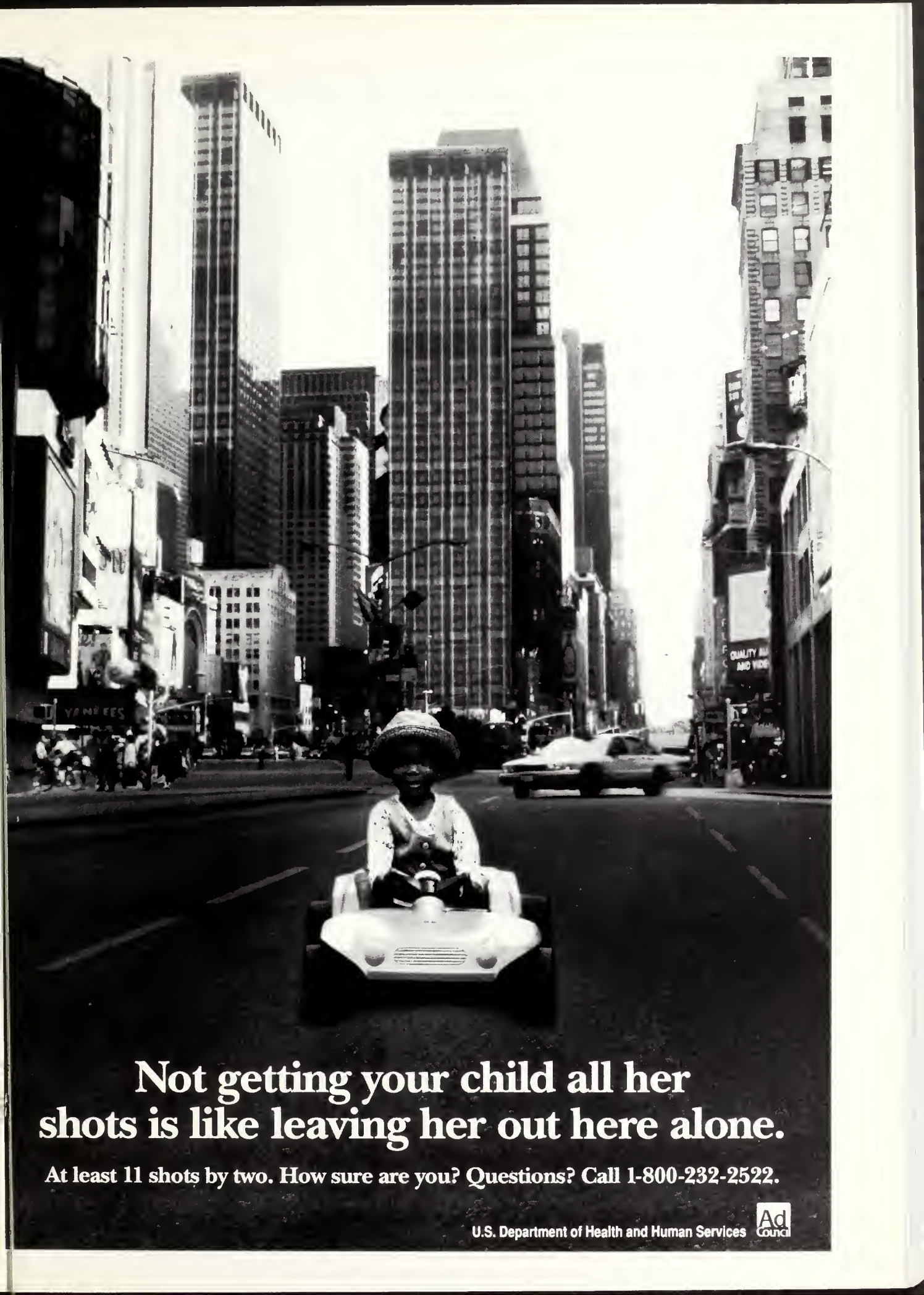
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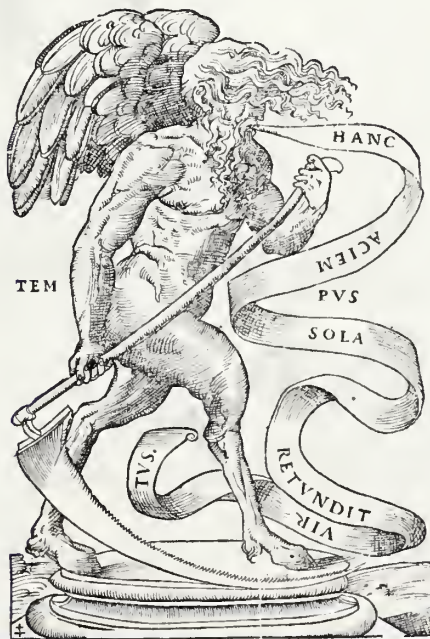
OF THE SOUTH CAROLINA MEDICAL ASSOCIATION



VOLUME 91
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JULY 1995
PAGES 291-328

**PRIMARY HYPERPARATHYROIDISM
BOCHDALEK HERNIA AND TRACHEOESOPHAGEAL
FISTULA
MENTAL RETARDATION AND MENTAL ILLNESS
SOUTH CAROLINA'S LAST YELLOW FEVER EPIDEMIC
THE AMA ANNUAL MEETING**

De dissectione partium corporis
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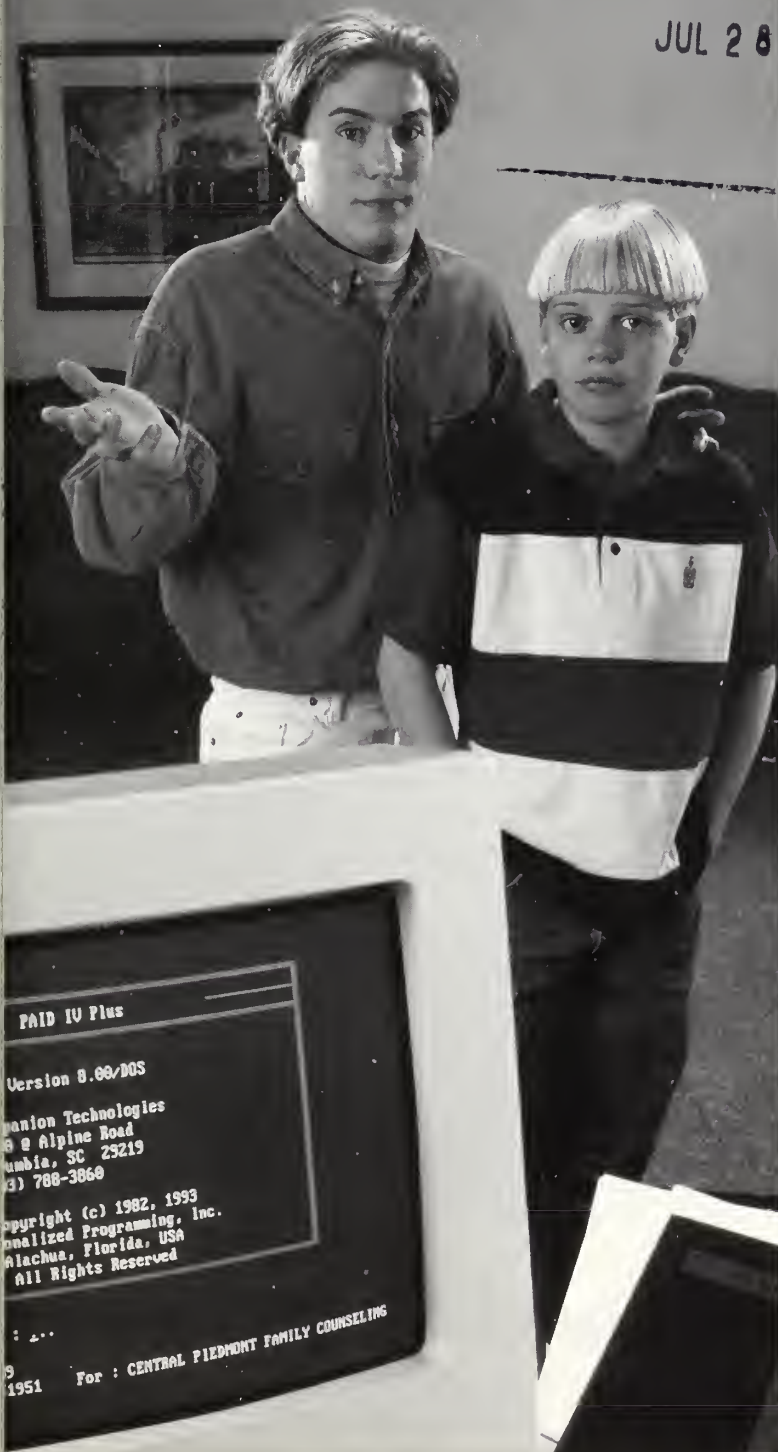
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President's Page

AMA ANNUAL MEETING — JUNE, 1995

By the time this editorial appears, your AMA delegation will have been to the AMA annual convention in Chicago, June 16-22, 1995. I want you to know what we do on your behalf and how the convention is conducted.

Dr. Walt Roberts leads the delegation. Other delegates are Doctors Dan Brake, Chris Hawk and Roger Gaddy, with Doctors Nelson Weston, John Simmons, Steve Imbeau and Marion Burton serving as alternate delegates. Also attending will be president-elect Dr. Carol Nichols, Mr. Bill Mahon, Mr. Steve Williams and myself.

We start work days before we get to Chicago by dividing all reference committee assignments among the delegation. Each member is responsible for reviewing the resolutions for his or her committee and providing a written synopsis of this voluminous material for the rest of the delegation to study. Arriving in Chicago on Friday, the delegation spends all day Saturday reviewing the resolutions and deciding how we will vote. Sunday morning we meet at 6:00 a.m. to collect and distribute information and pertinent materials. At 7:00 a.m., we have breakfast with the Southeastern Coalition delegates to discuss resolutions of particular interest to our region. The House of Delegates convenes at 9:30 a.m. and lasts all morning.

Sunday afternoon and Monday morning, we go to meetings of our respective reference committees where resolutions are discussed, elected and put into final forms. The House of Delegates continues to meet on Tuesday, Wednesday and Thursday. Tuesday night, the SC delegation will host a reception for Dr. Randy Smoak, who is running for reelection to the AMA Board of Trustees. Wednesday night, I will attend Dr. Lonnie Bristow's inauguration as the new AMA president. (Many of you may have met Dr. Bristow in 1994 at the SCMA Annual Meeting in Charleston.)

As you can see, this crowded agenda leaves us little leisure time. We work long hours to represent the SCMA well and to keep up with the issues being presented and discussed, many of which are vital to our patients' and our profession's future. I hope that this synopsis of our schedule and activities helps you to understand what your delegation does to serve your interests on the national level of organized medicine.

Benjamin E. Nicholson, M. D.
President

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THE DIAGNOSIS AND MANAGEMENT OF PRIMARY HYPERPARATHYROIDISM

DABNEY R. YARBROUGH, III, M. D.*

Felix Mandl of Vienna is generally credited with the first parathyroidectomy for hyperparathyroidism in 1925. His patient developed recurrent hypercalcemia six years after initial surgery and ultimately died of the effects of hyperparathyroidism.¹ Over the years following this initial operation, hyperparathyroidism has continued to present a fascinating diagnostic and technical surgical challenge to the physician. The incidence of diagnosis of sporadic primary hyperparathyroidism has increased significantly in recent years. Many authorities feel that the increase in incidence of hyperparathyroidism is attributable more to the increased rate of discovery of asymptomatic hypercalcemia and its investigation than to a true increase in the rate of occurrence of the disease. In any event, primary hyperparathyroidism is being seen more frequently by physicians.¹ An added dimension of interest of this disease to the surgeon is the technical challenge that surgery for hyperparathyroidism may present. In order to emphasize diagnostic and surgical points of importance in the management of this disease a series of cases of primary hyperparathyroidism treated by the author over a recent five-year period was reviewed.

PATIENT DATA

During the time period of the review (1990-1994) a total of 58 patients with primary hyperparathyroidism were treated by the author. Patients with secondary and tertiary hyperparathyroidism and patients presenting for re-exploration after failed procedures were excluded from the study. There were 47 females and 11 males in the study yielding a female to male ratio of approximately 5:1. The average age of the patients was 56 years with ages ranging from 20 years to 84 years. Forty-three patients were essentially asymptomatic at the time of diagnosis while the remaining 15 patients presented with symptoms of severe osteoporosis (four patients), renal stones (six patients) or mental changes ranging from memory loss or intermittent confusion to profound obtundation (five patients). In retrospect, 12 of the 43 patients preoperatively deemed to be asymptomatic reported dramatic improvements in strength and energy levels or mental function postoperatively suggesting a causal relationship of these symptoms to their hyperparathyroidism.

Two patients had known pre-existing peptic ulcer disease, six had gout and one had a history of pancreatitis. One patient was pregnant at the time of diagnosis and underwent excision of

*Department of Surgery, Medical University of South Carolina, 171 Ashley Avenue, Charleston, SC 29425.

a parathyroid adenoma during the second trimester. One patient had a history of radiation treatments to the head and neck in childhood. Five patients had concurrent benign thyroid nodules while two had concurrent thyroid cancer (one papillary and one follicular).

All but two patients in this series were referred to the author after an essentially complete diagnostic workup. All patients had had persistent hypercalcemia and elevated serum parathormone levels. Fifty of the 58 patients had had parathyroid scans or ultrasound examinations. These imaging studies were inconclusive in eight of the 50 patients. Parathyroid adenomas measuring one cm. or more were found in six of the eight cases in which imaging studies had been inconclusive while parathyroid hyperplasia was documented in the remaining two cases. There was one inaccurate ultrasound examination and one inaccurate thallium-technetium scan localizing abnormal parathyroids to the opposite side of subsequently surgically proven parathyroid adenomas. In both instances the imaging appearance was probably attributable to the presence of thyroid nodules. The one patient in whom exploration was unsuccessful had an ultrasound examination preoperatively suggestive of a parathyroid adenoma. Imaging studies appeared to be accurate in 40 of the 50 patients in this series in whom they were performed (80 percent).

All patients in the series underwent neck exploration. Fifty-five patients (95 percent) had parathyroid adenomas, two (three percent) had parathyroid hyperplasia and one (two percent) had no parathyroid pathology found. There were no cases of parathyroid carcinoma in this series. The 55 patients with parathyroid adenomas underwent excision of the adenoma in addition to identification of normal parathyroids while the two patients with parathyroid hyperplasia underwent subtotal parathyroidectomy (excision of 3 1/2 parathyroids with in situ preservation of a parathyroid remnant). In the two patients with concurrent thyroid cancer, total thyroid lobectomy was performed in one patient with a small follicular carcinoma while total thyroidectomy was performed in the

patient with papillary carcinoma who had a history of head and neck radiation in childhood.

Postoperatively the one patient who had no surgically demonstrated parathyroid pathology has remained hypercalcemic and has refused re-exploration as of the time of this review. One patient developed symptomatic hypocalcemia postoperatively requiring temporary calcium supplementation. The hypocalcemia in this patient resolved spontaneously and calcium therapy was terminated. The overall surgical success rate in this series was 98 percent. There were no deaths and no recurrent laryngeal nerve injuries in the series.

DISCUSSION

The diagnosis of hyperparathyroidism is essentially the differential diagnosis of hypercalcemia and has been greatly simplified in recent years by the wide-spread availability of reliable serum parathormone assays. Persistent hypercalcemia coupled with an inappropriately elevated serum parathormone level are the foundation of diagnosis and rule out the majority of other differential diagnostic possibilities with the rare exception of patients with pure parathormone producing non-parathyroid malignant tumors. Relatively inexpensive studies of additional confirmatory value include the demonstration of hypophosphatemia and an increased serum chloride:phosphate ratio (usually greater than 33:1 in patients with primary hyperparathyroidism).

Some of the more common considerations in the differential diagnosis of hypercalcemia in addition to malignant tumors (most commonly carcinoma of the lung and hypernephroma) include increased intake of milk products, antacids, calcium or vitamin D, multiple myeloma, granulomatous diseases (sarcoid, tuberculosis, berylliosis), other endocrine disorders (hyper- and hypothyroidism, Addison's disease, pheochromocytoma) and certain drugs that may cause hypercalcemia (e.g., thiazide diuretics, lithium).² Familial hypocalciuric hypercalcemia must also be considered in the differential diagnosis.

Due to the relatively low order of accuracy,

expense and in some instances high risk, the various localizing imaging techniques (CT, MRI scans, ultrasound, radionuclide scans, arteriography, differential venous parathormone sampling) are not unanimously recommended by experienced parathyroid surgeons in the workup of uncomplicated cases.² Although confidence in the diagnosis is increased by a positive imaging study resulting in facilitation of surgical exploration and probably earlier referral for surgery, their cost-effectiveness remains debatable. Of the currently available types of localizing studies the relatively recently available sestamibi scan appears to be the most reliable. The majority of localizing studies are accurate in approximately 80 percent of cases with possibly a somewhat greater degree of accuracy with the sestamibi scan. An experienced parathyroid surgeon should be able to correctly identify the parathyroid abnormality in more than 90 percent of cases. Accordingly it has often been said that the most reliable technique for localizing parathyroid pathology is to localize an experienced parathyroid surgeon. An acceptably accurate, cost-effective workup consists of a complete history and physical examination, demonstration of persistent hypercalcemia, an inappropriately elevated serum parathormone and an ultrasound examination highly suggestive of parathyroid enlargement.

Most authorities recommend surgical management for all patients with primary hyperparathyroidism whose general condition permits. Although some have advocated continued observation for asymptomatic patients with minimal hypercalcemia (serum calcium less than 1 mg above the upper limits of normal) most studies have indicated that even in this group of patients most will ultimately develop complications necessitating surgery.³

Parathyroid operations are performed through a standard Kocher thyroid incision with identification of all four parathyroids in the majority of cases. In recent years there has been enthusiasm in some quarters for unilateral neck exploration if one normal and one clearly enlarged parathyroid gland are identified.⁴ Preoperative

localizing studies may facilitate this approach. It must be recognized however that when using this approach the possibility of incomplete extirpation of all hyperfunctioning parathyroid tissue is theoretically increased by two to five percent. With unilateral exploration double adenomas may be missed (up to five percent of cases) as well as hyperplasia involving less than four glands (two to five percent of cases). We currently advocate bilateral exploration in all but the very elderly or high-risk cases. During exploration care must be taken to avoid injury to the recurrent laryngeal nerve. In cases of parathyroid adenomas the adenoma is resected while in cases of hyperplasia the most normal appearing gland with the best blood supply should be biopsied for confirmation, then partially resected with total resection of the remaining three glands.

Postoperatively, the patient's serum calcium should be monitored until stable prior to discharge. Calcium supplementation is not begun unless the patient develops symptomatic hypocalcemia. Recently there has been some interest in beginning oral calcium immediately after surgery in all patients with a view to discharging the patient on the first postoperative day. The results of this management protocol have not yet been completely evaluated.²

SUMMARY

Primary hyperparathyroidism is being diagnosed with increasing frequency in recent years due to more widespread availability and reliability of the various appropriate diagnostic tests. Except in unusual circumstances patients with documented primary hyperparathyroidism are probably best served by early operation performed by an experienced parathyroid surgeon. Under such circumstances cure rate should approximate 95 percent, with less than a one percent incidence of recurrent laryngeal nerve injury or permanent hypoparathyroidism. The cure rate in the currently reported series of cases was 98 percent with no instances of recurrent laryngeal nerve injury or permanent hypoparathyroidism.



REFERENCES

1. Thomas, Colin G: Presidential Address: The Glands of Owen-A perspective on the history of hyperparathyroidism, *Surgery*, 108:939, 1990.
2. Kaplan, EL, Yashiro, T and Salti, BA: Primary hyperparathyroidism in the 1990s. *Ann. Surg.*, 215:300, 1992.
3. Palmer, M: Survival and renal function in persons with untreated hypercalcemia: A population based cohort study with 14 years of follow-up. *Lancet*, 1:59, 1987.
4. Potts, JT, Ackerman, IP and Barker, CF: Diagnosis and management of asymptomatic primary hyperparathyroidism: Consensus development conference statement. *Ann. Intern. Med.*, 114:593, 1991.

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SCMA NEWSLETTER

A PUBLICATION OF THE SOUTH CAROLINA MEDICAL ASSOCIATION
Joy Drennen, Editor
798-6207, in Columbia

Contributions welcomed
1-800-327-1021, outside Columbia

July, 1995

MEDICARE UPDATE

By now you should have received the *Medicare Advisory* for July, 1995. This is a large advisory with a lot of information which you should read carefully. Included is a question and answer section regarding Free Standing Rural Health Clinics and a clarification on Care Plan Oversight services.

Nonphysician Practitioners' License Renewals: All nonphysician practitioners must renew their licenses on an annual basis. The Medicare Part B provider number is effective only during the dates listed on your license. When you renew your medical license, remember to send the Medicare Part B Provider Certification Department a copy of your new license.

Claims Mailing Address Reminder: Medicare Part B Claims should be mailed to: *Medicare Part B Claim Processing, Palmetto Government Benefits Administrators, P.O. Box 100190, Columbia, SC 29202-3190.*

Action Code IP: This code indicates that Medicare does not pay for the service for the diagnosis stated. If you receive a claim denial with this action code, you should check the diagnosis code you've reported for that procedure. Most medical policies published in the *Medicare Advisory* include diagnosis code information that may be useful. If you discover another diagnosis code that better explains why the procedure was necessary, you should refile that line of service electronically or on a separate claim form. Do not mark "corrected claim" on the claim form.

Mammography Quality Standards ACT (MQSA): All screening mammography facilities have been issued a six-

digit alphanumeric number by the FDA. Effective for claims with dates of services on or after July 1, 1995, all providers billing for the global or technical component of a diagnostic or screening mammography must include the FDA certification number in item 32 of the HCFA claim form. Claims received without the FDA certification number will be denied or delayed.

Medicare Secondary Payer Teleconference Scheduled for August: Medicare Part B will be hosting a teleconference to discuss Medicare Secondary Payer issues on August 24 from 1:00 to 3:00 pm. The teleconference will be broadcast on the Health Communication Network. My Tom Nyzio, manager of the Medicare Part B Secondary Payer Department, will review coverage criteria and answer questions. **If you'd like to submit a topic for Mr. Nyzio to discuss, please complete the form from the July, 1995 Advisory and mail it to the address listed on the bottom of the form.**

Coding for Failed Colonoscopy: A failed colonoscopy, e.g., the inability to extend beyond the splenic flexure, should be billed and paid as a sigmoidoscopy, (CPT code 45330) rather than a colonoscopy, since this is the procedure that was actually performed.

As with other services, modifier 22 should be used and extra payment allowed only when supporting documentation indicates that significantly more time and effort is involved than is required in the typical sigmoidoscopy.

The site-of-service reduction would apply when the sigmoidoscopy/failed colonoscopy is done in the hospital setting. □

MEDICAID UPDATE

Name Change: As of July 1, 1995, the SC Health and Human Services Finance Commission (SCHHSFC) will become a cabinet agency. The new agency name will be the Department of Health and Human Services (DHHS).

Ambulatory Visits: The fiscal year for DHHS runs from July 1 to June 30. Medicaid patients (age 21 and older) are limited to 12 ambulatory care visits per year, commencing with dates of service on or after July 1 of each year. Medicare/Medicaid recipients, family planning recipients, and children under age 21 are exempt from this limitation.

Rejections for Exceeding the Ambulatory Visit Limit: As a reminder, DHHS is in the process of implementing an affidavit process for providers receiving a 977 edit code. A Medicaid card will be honored only when the card for the month of their visit indicated the recipient had six or fewer visits. The provider will have to certify this through an affidavit and attach a copy of the card before the claim can be processed. A forthcoming bulletin will have detailed instructions.

Fiscal Year Billing Note: Please do not use procedure codes for multiple visits on a single line that will cause the units to cross fiscal years. One line of the multiply-

ing code should be billed to reflect days billed on or before June 30. A second line on the claim should reflect the days billed on or after July 1. If a line is billed that crosses fiscal years, edit code 774 will be generated.

Physician Standby Services: The grace period for the use of procedure codes 99150 and 99151 has been extended to July 31, 1995. CPT codes 99360 and 99361 may be used to replace 99150 and 99151 as of June 1, 1995, for physician standby services not involving direct (face to face) contact. Effective with dates of service on or after August 1, 1995, only codes 99360 and 99361 may be used to report standby services. Please refer to the forthcoming bulletin for further details.

Billing Workshop: The Department of Physician Services will be offering a basic billing workshop on August 2, 1995, at 12:30 pm. The workshops are designed for new billing staff and new providers in the SC Medicaid Program. The workshop will be held in the Jefferson Square Plaza at 1801 Main Street in the third floor conference room. Due to limited training space, reservations are required. Please contact your program manager at (803) 253-6134 to reserve a space. The basic billing workshops are offered free on a quarterly basis. ☐

PROPOSED MEDICARE/MEDICAID BUDGET CUTS

In an effort to balance the federal budget, the House and Senate are proposing major reductions in future Medicare and Medicaid spending. In a budget resolution, which will be introduced in both houses, House and Senate leaders agreed to reduce Medicare spending \$270 billion and Medicaid spending \$182 billion between 1996 and 2002.

Once the final budget resolution is passed by both houses, the authorizing committees are responsible for approving the legislative changes necessary to accomplish the spending reductions.

The final Medicare and Medicaid changes are not expected to be finalized until September or October.

SCMA ANNUAL MEETING: 1996

The 1996 SCMA Annual Meeting and Scientific Assembly will be held again in Charleston at the Omni Hotel, April 25-28, 1996.

Mark your calendars now!

MANAGED CARE ALERT

In the past month, some of you may have received letters offering the "opportunity to be included on an exclusive provider panel in the state of South Carolina." These letters indicate this panel will be "limited to approximately 18 percent of the practicing physicians in each specialty." To be considered for this exclusive panel, **physicians only** are urged to call a 1-800 number within four business days. At that time, you will speak with a provider relations representative who will explain the panel selection process to you. Upon completion of your reservation process, you will be forwarded a Provider Agreement and Credentialing Packet. Most importantly, you are asked to provide a \$250 fee for the application. Some companies are even requesting you fax a check to them so that they may obtain your account information.

The SCMA has received numerous inquiries about this special offer. **We suggest that you act cautiously when considering participation on any provider panel, particularly if undue urgency seems attached, or a financial investment is required.**



VOLUNTEERS NEEDED

Volunteer physicians, nurses, and allied medical personnel are needed for short term service with RAM (Remote Area Medical), a Knoxville TN-based private volunteer group. Most trips last one week, to US Indian Reservations, Mexico, Haiti, Guatemala, and others. Room and board are furnished. Some openings are available now; others are year round, with all specialties needed.

For information, call A. A. Stamler, MD, (803) 834-1945, or Remote Area Medical, (615) 688-4081. □

SCMA CHIEF EXECUTIVE OFFICER AWARDED AMA MEMBERSHIP

William F. Mahon, Chief Executive Officer of the SCMA, was awarded affiliate membership status in the AMA at the AMA's annual meeting Sunday, June 18, 1995. He received affiliate membership for having achieved distinction in his field of endeavor. The AMA Council on Ethical and Judicial Affairs provides nominations for affiliate membership and nominations are approved by the AMA House of Delegates.

Mr. Mahon currently serves on the American Association of Medical Society Executives' Advisory Committee to the AMA Executive Vice President, Dr. James Todd; the Board of the South Carolina Business and Industry Political Education Committee; the South Carolina Rural Physicians Incentive Board, the South Carolina Data Oversight Council and the Health Care Technology Task Force.

He is a graduate of the Governors State University in Park Forest South, Illinois and Moraine Valley Community College, Palos Park, Illinois.

(For details of the AMA Interim Meeting, see the report by Walter J. Roberts, Jr., MD, elsewhere in this issue of The Journal.)

PHYSICIANS CARE NETWORK UPDATE

As this newsletter goes to press, HealthSouth Rehabilitation Hospital in Charleston has just been added to the PCN. There are now 2,850 physician members of the PCN and 47 hospitals.

If you have questions regarding the PCN, please call Barbara Whittaker at SCMA Headquarters in Columbia at 798-6207, or statewide 1-800-327-1021, ext. 226. □

UPDATE: SCMA WORKSHOPS

You are reminded of the following SCMA Workshops:

<u>Subject</u>	<u>Dates and Locations</u>
"Appealing Unfair Payments"	August 16, 1995, Columbia Sheraton Hotel and Conference Center Two sessions: 9:00 am-12:00 noon or 1:30-4:30 pm
"Effective Collection Strategies"	September 13, 1995, Columbia Sheraton Hotel and Conference Center 9:00 am-4:00 pm
"Capitation Strategies for Practice Survival"	October, 1995, Charleston and Columbia Dates and sites to be announced

TOWN HALL SERIES ON HEALTH CARE

Palmetto Project and South Carolina Educational Television (SC ETV) will host a three-part series on the status of health care in South Carolina. The series will explore the changes in the health care industry and their impact on the average South Carolinian, the evolving role of the health care consumer, and ethical choices in deciding who gets what and why. The goal of the series is to provide an objective overview, or snapshot, of health care issues in South Carolina and its implications for the average citizen. All segments can be seen on SC ETV at 8:00 p.m.

The topics and air dates are as follows:

- "The Changing Landscape of the South Carolina Health Care Industry"
SCMA President, Dr. Benjamin E. Nicholson, is featured as a panelist for this discussion
Tuesday, August 1, 1995
- "South Carolina's Health Care Consumers"
Tuesday, August 8, 1995
- "Health Care's Tough Choices: Who Gets What and Why"
Tuesday, August 15, 1995



OMNIBUS ADULT PROTECTION ACT REGIONAL TRAINING

The Adult Protection Coordinating Council is pleased to provide training on the Omnibus Adult Protection Act for health and human service administrators and professionals, long term care administrators, and law enforcement personnel who serve the elderly and persons with disabilities who may be at risk for abuse, neglect or exploitation.

The first training in the state will be held on September 15, 1995 at Charleston County DSS, 3346 Rivers Avenue, Suite A, North Charleston, SC. CEUS for long term care administrators, social workers and law enforcement personnel will be available. There is no fee but the deadline for registration is August 15, 1995. *For further information, contact Sharon S. Chewning, PO Box 8206, Columbia, SC 29202-8206. Phone (803) 253-6142; Fax (803) 253-4154.*



SIMULTANEOUS BOCHDALEK HERNIA AND TYPE C TRACHEOESOPHAGEAL FISTULA

DAVID J. NOWICKY, M. D.*

Various types of tracheoesophageal fistula and diaphragmatic hernia have been studied and their embryological deviations outlined. The simultaneous occurrence of these two potentially life-threatening conditions, especially in conjunction with esophageal atresia, is extremely unusual; in 1983 Bowen reported only 10 previous cases.¹ Although some of these infants suffer from chromosomal abnormalities, this combination of conditions follows no identifiable pattern of inheritance or monogenic syndrome.² The rarity of finding them in the same patient lulls the clinician away from the original diagnosis until the infant fails to respond favorably to interventions.

CASE REPORT

D.B., a 33-week gestational age male weighing 1610 g, had been delivered by cesarean section for a breech presentation to a Gravida II Para I single female. Complications accompanying labor had included a 25 percent abruption and fetal decelerations. Apgar scores at 1, 5, and 10 minutes were 2, 5, and 5 respectively; because of immediate respiratory distress, the infant was endotracheally intubated.

He continued to exhibit severe respiratory difficulty and presented with asymmetric chest movements, a scaphoid abdomen, and audible breath sounds in the left hemithorax, all suggesting a congenital diaphragmatic hernia (CDH). Initial chest x-ray revealed left-sided intrathoracic distended loops of bowel. The patient was taken for emergency repair of his CDH through the standard transabdominal approach. The distended stomach was removed from the thoracic cavity, but attempts to pass a nasogastric (NG) tube distally were unsuccessful, and the stomach continued to pulsate with

ventilations.

Preoperatively it had been presumed that the NG tube was kinking from the contorted position of the abdominal contents, but when attempts to advance it failed, an esophageal atresia with tracheoesophageal fistula (TEF) was diagnosed (Figure 1). The endotracheal tube was advanced just distal to the fistula, and a Stamm gastrostomy was placed for bowel decompression. Other intraoperative findings included an incomplete intestinal rotation and a large left-sided Bochdalek hernia which was repaired with prosthetic graft material.

The patient returned to the operating room



Figure 1: Initial roentgenogram of chest and abdomen demonstrating coiling of NG tube in proximal esophageal pouch. Note the left-sided diaphragmatic hernia and the extreme displacement of the cardiac silhouette into the right hemithorax.

*Department of Surgical Education, Greenville Hospital System, 701 Grove Road, Greenville, SC 29605.

seven days later for a right thoracotomy and extrapleural repair of his proximal esophageal atresia and distal TEF. He tolerated both procedures quite well, but his postoperative course was complicated by bronchopulmonary dysplasia, patent ductus arteriosus (which required no intervention), significant gastroesophageal reflux, and hyperbilirubinemia. Chromosomal studies demonstrated normal karyotype. Post-op barium swallow showed a mild esophageal stricture but otherwise documented adequate repair. The patient was discharged at nearly three months of age.

About six weeks later, the infant arrived in the emergency room in full cardiac arrest and apnea unresponsive to advanced resuscitative measures. Post mortem examination revealed residual bronchopulmonary dysplasia and pulmonary congestion. Cause of death was presumed secondary to sudden infant death syndrome (SIDS) or infantile apnea syndrome.

DISCUSSION

Although no management protocols have been developed for treatment of the combination of CDH, esophageal atresia, and TEF, the literature describes certain procedures necessary for containment. It is critical to decompress the gastrointestinal tract adequately while ventilations to the pulmonary circuit continue.¹ Only then can the underlying pulmonary derangements—such as hypoplasia, cyanosis, and hypoxia—begin to reverse.

Several methods have been developed to prevent gaseous distention of the bowel while definitive repair can proceed. Nasogastric suction is impossible with a proximal esophageal atresia, a key component, unfortunately, of the most common TEF. One can selectively cannulate the stomach through the TEF itself, either through the endotracheal tube, as described by Rawlings,³ or separately. Another method utilizes bronchoscopy to guide a Fogarty catheter down to the level of the TEF to occlude the abnormal connection to the bowel.⁴ Selective endotracheal intubation of the lung contralateral to the diaphragmatic hernia can also be per-

formed.⁵ Theoretically, this third option would provide more directed ventilations, thus bypassing the hypoplastic lung fields.

Even with adequate operative repair of both the Type C tracheoesophageal fistula and congenital diaphragmatic hernia (either staged or performed simultaneously), mortality rates for these infants probably remain high (as with our patient, who eventually succumbed to SIDS). These infants present very fascinating clinical challenges which demand prompt recognition and expert technical skill. An awareness that such conditions can occur simultaneously will increase the clinician's effectiveness in attempting to help these children.

SUMMARY

The occurrence in an infant of coexisting congenital diaphragmatic hernia, proximal esophageal atresia, and distal tracheoesophageal fistula is extremely rare, and the literature contains only anecdotal reports of treatment. Because these infants often have challenging clinical presentations and may deteriorate rapidly, physicians should be aware of manifestations of this combination of conditions and how to manage them. □

ACKNOWLEDGMENT

The author wishes to thank Nancy Dew Taylor, Ph. D, for editorial assistance in the preparation of this manuscript.

REFERENCES

1. Bowen A. The ventilatory dilemma of coexisting diaphragmatic hernia, esophageal atresia, and tracheoesophageal fistula. *Crit Care Med*; 11:390-391, 1983.
2. Martinez-Frias ML, Frias JL, Salvador J. Clinical/epidemiological analysis of malformations. *Am J Med Genet*; 35:121-125, 1989.
3. Rawlings JS, Shetler PL, Fill WL, Cathcart CF. Concurrent right diaphragmatic hernia and type C tracheoesophageal fistula. *Clin Pediatr*; 23:518-520, 1984.
4. Filston HC, Chitwood WR Jr., Schkolne B, Blackmon LR. The Fogarty balloon catheter as an aid to management of the infant with esophageal atresia and tracheoesophageal fistula complicated by severe RDS or pneumonia. *J Pediatr Surg*; 17:149-151, 1982.
5. Brooks JG, Bustamante SA, Koops BL, et al. Selective bronchial intubation for the treatment of severe localized pulmonary interstitial emphysema in newborn infants. *J Pediatr*; 91:648-652, 1977.

A HABILITATION CENTER FOR INDIVIDUALS WITH A DUAL DIAGNOSIS OF MENTAL RETARDATION AND MENTAL ILLNESS*

FÉ A. CARDONA, M. D., M. P. H.**

PAUL K. SWITZER, III, M. D.

The Intermediate Care Facility for the Mentally Retarded (ICF/MR) is the sole agency in the State of South Carolina that is licensed by the South Carolina Department of Health and Environmental Control (DHEC) as a habilitation center to serve individuals with a dual diagnosis of mental retardation and mental illness. These individuals carry a primary diagnosis of mental retardation and a secondary diagnosis of mental illness.

The ICF/MR is designed to provide services to meet the special and varied needs of the developmentally disabled individual and his family. There are two principles upon which the ICF/MR is based: developmental model and normalization. First, in the developmental model, every individual has the potential for growth, learning and development, no matter how severely handicapped he might be. Second, in the normalization principle, each individual is given the opportunity to live as normal as possible in a manner analogous to the norms and patterns of the mainstream of society.

The ICF/MR is licensed by DHEC to operate and maintain a maximum of 70 beds. The main source of funding is Title XIX (Medicaid) of the Social Security Act with minimal contribution from State Aid and private insurance.

GOAL

The basic goal of the ICF/MR is to place the developmentally disabled individual in the least restrictive environment to enable him to

integrate to community life as soon as feasible.

CRITERIA FOR ADMISSION

1. Above 22 years of age.

Due to Public Law 94-142 (Education for All Handicapped Children Act of 1975) which mandates free and appropriate education to all handicapped individuals from three years of age to 22, no individual below 23 is admitted to the facility.

2. Dual diagnosis of mental retardation and mental illness.

Mental retardation refers to a significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period (AAMR, 1983). Specifically, subaverage general intellectual functioning means a full scale Intelligence Quotient (IQ) below 70. The corresponding IQ for the different levels of mental retardation are:

Mild	50-55 to approximately 70
Moderate	35-40 to 50-55
Severe	20-25 to 35-40
Profound	Below 20 or 25

Mental illness is a condition in which an individual lacks sufficient insight or capability to make responsible decisions with respect to his/her treatment and/or there is likelihood of serious harm to self or others.

3. Ability to participate in active treatment.

Active treatment is an ongoing process with consistent implementa-

*From Crafts-Farrow State Hospital, South Carolina Department of Mental Health, Columbia, SC.

**Address correspondence to Dr. Cardona at ICF/MR, Crafts-Farrow State Hospital, 7901 Farrow Road, Columbia, SC 29203.

TABLE 1. LEVELS OF MENTAL RETARDATION

Degree of Intellectual Impairment	Number	Percent
Mild	30	68%
Moderate	9	21%
Severe	2	4.5%
Profound	3	6.5%

tion of either specialized or generic programming that provides services directed towards: (1) the acquisition of the behaviors necessary for the individual to function with self-determination and independence and (2) the prevention of further regression or loss of current optimal functioning.

POPULATION SERVED

The ICF/MR serves individuals, both males and females whose age range vary from above 22 to below 70. At the time this paper was written (February 1994), the patient census was 44. These patients were admitted to the facility between September 1990 and August 1993.

Table 1 summarizes the patients' levels of mental retardation.

The patients carry 49 psychiatric diagnoses which are based on DSM-III-R, 1987. Table 2 illustrates these diagnoses.

In addition to mental retardation which is a developmental disability, 19 of these patients have other underlying or related developmental disabilities. The definition of developmental disability as applied in this paper is adopted from Public Law 95-602, "Rehabilitation, Comprehensive Services and Developmental Disabilities Amendments of 1978."

The developmental disabilities include Physically Handicapped – Visual Impairment (6), Communicatively Handicapped – Speech Impairment (3), Drug Abuse (3), Alcohol Abuse (3), Both Alcohol and Drug Abuse (2), Cerebral Palsy (1) and Orthopedically Handicapped – Degenerative Arthritis of the Spine and Hip (1).

Figure 1 illustrates the percentage of these developmental disabilities.

Forty-one associated medical conditions were identified in these patients. They encompass conditions affecting various systems such as cardiovascular, dermatologic, endocrine, gastrointestinal, gynecological, hematological, metabolic/nutritional, neurological, ophthalmological, otolaryngological, pulmonary, skeletomuscular and urological.

The five most common systems affected are the central nervous system (17), cardiovascular (9), hematopoietic (5), endocrine (4), and gastro-intestinal (4).

The five most conditions identified under the different systems are Epilepsy (12), Hypertension (5), Anemia (5), Diabetes Mellitus (2), and Cardiac Conduction Disorder (2). The percentage of each is shown in Figure 2.

INTERDISCIPLINARY TEAM PROCESS

Intrinsic in the developmental model is the interdisciplinary team process which addresses the multiple, complex and changing needs of the individual and his family. These needs include but are not limited to social, psychological, financial, educational, medical and vocational. The team includes a physician,

Figure 1. Related Developmental Disabilities

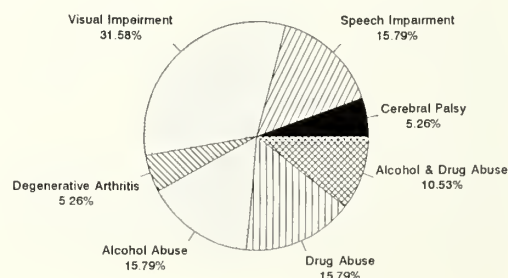
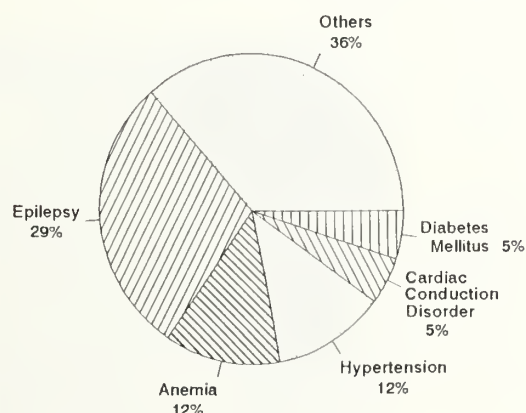


TABLE 2. PSYCHIATRIC DIAGNOSIS BASED ON DSM-III-R

Diagnosis	Number	Percentage
Schizophrenia (Total)	22	45%
Types:		
Chronic Undifferentiated	(15)	(31%)
Paranoid	(5)	(10%)
Catatonic	(1)	(2%)
Disorganized	(1)	(2%)
*Psychotic Disorder Not Otherwise Specified (NOS)	4	8%
*Obsessive Compulsive Disorder	3	6%
Persuasive Developmental Disorder	2	4%
Schizoaffective Disorder	2	4%
*Intermittent Explosive Disorder	2	4%
*Atypical Psychosis	2	4%
Adjustment Disorder	1	2%
*Antisocial Personality Disorder	1	2%
Depressive Disorder (NOS)	1	2%
Major Depression	1	2%
Dysthymia (Depressive Neurosis, (NOS)	1	2%
Impulsive Control Disorder	1	2%
Organic Delusional Disorder	1	2%

* Five patients have double psychiatric diagnosis.

Figure 2. Five Most Common Medical Conditions



social worker, psychologist, vocational counselor, nurse and special therapists such as physical, occupational and speech and hearing. This team of professionals is a unique structure through which each can best make his contribution in assisting the individual and his family develop a life program through the Individual Program Plan (IPP).

INDIVIDUAL PROGRAM PLAN

Upon admission to the ICF/MR, an Individ-

ual Program Plan (IPP) is developed for each individual with the collaborative effort of the interdisciplinary team.

The IPP is based on the assessment of each member of the team. The strength and needs of the individual are identified and objectives for program activities are developed to address these needs within a specified period of time.

MEDICAL CARE PLAN

A Medical Care Plan is developed by a physician for patients who are ill or at medical risk requiring a 24-hour licensed nursing care. Patients with chronic but stable health problems such as controlled epilepsy, diabetes mellitus and others do not require a Medical Care Plan.

BEHAVIOR MANAGEMENT PLAN

A Behavior Management Plan (BMP) is developed for each individual who exhibits maladaptive behavior/s. The components of a BMP include the target behavior/s, objectives to eliminate the behavior or to establish new behaviors in lieu of the target behavior, ratio-

nale for the behavior, methods of intervention and staff responsible in implementing the plan.

Essential to the development of a BMP is vital information which includes the nature, characteristics, frequency, intensity and events occurring prior to and/or concurrent with the behavior.

PSYCHOTROPIC DRUG THERAPY

When an individual has a drug responsive psychiatric disorder, psychotropic drug therapy is used in conjunction with the BMP. The psychotropic drugs used in the ICF/MR include antipsychotics, antidepressants, anxiolytics and mood stabilizers. Informed consent is obtained if the individual is capable of giving consent or from the legal guardian. Approval is also obtained from the Human Rights Committee which is an independent agency that protects the rights of the individuals.

PROGRAM

The intent of programming for developmentally disabled individuals is to maximize their human qualities through active treatment. This is addressed through programs in the Residential and Developmental Training Services.

A. Residential Services

Individuals are provided round the clock supervision to ensure that they attain their maximum level of skill development. They are trained commensurate with their skills in the following areas:

1. Activities of Daily Living: These include the normal routine of life such as feeding, personal hygiene and grooming.
2. Functional Living Skills: These embody experiences allied to the normal patterns of the mainstream of society such as communication, social/interpersonal skills, home living, use of community resources, health and safety.

B. Developmental Training Services

The individuals are provided a variety of vocational training programs for future potential occupational pursuits. The training comprises:

1. Hourly Wage: Individuals are paid depending upon the amount of work completed.
2. Incentive Price Rate: Individuals are paid depending upon the number of packages for a particular task correctly completed.

In carrying out these programs, the resources of many agencies and the expertise from diverse professional fields are essential for a concerted effort to allow the individual to function at his maximum potential.

SUMMARY

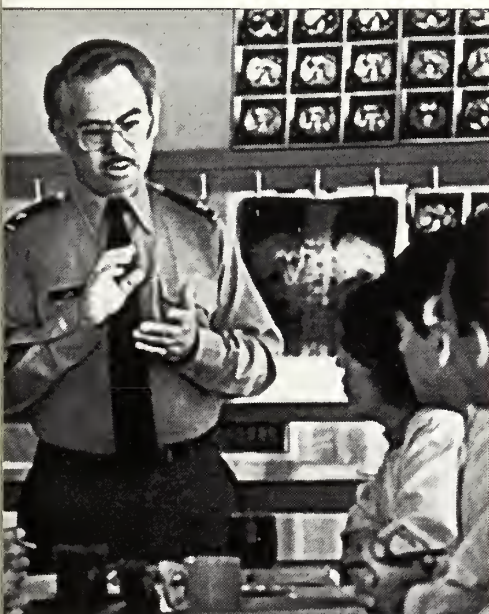
The ICF/MR provides services to individuals with a dual diagnosis of mental retardation and mental illness. These services prepare these individuals to the least restrictive environment analogous to the norms and patterns of the mainstream of society. The individuals served are more than 22 years of age and have behavioral problems associated with mental retardation and/or mental illness. In addition, they have multiple medical problems which are related or unrelated to their physical or mental disabilities. These individuals have multiple changing needs which are addressed by an interdisciplinary team. The team develops a unified Individual Program Plan which is the framework for a comprehensive care for these individuals. This is to enable them to live a normal life as possible and to achieve gainful occupational pursuits like any other citizen in the State of South Carolina. □

REFERENCES

1. Scheerenberger, RC: A History of Mental Retardation. Paul H. Brookes Publishing Company, Baltimore and London, 1983.
2. Baumeister, A: Mental Retardation; Appraisal, Education and Rehabilitation. Aldine Publishing Company, 1974.
3. Nirje, B: A Scandinavian Visitor Looks at U. S. Institutions. Wolfensberger, W and Kugel, R (Eds). Changing Patterns in Residential Services for the Mentally Retarded, pp. 51-58. Washington, D.C.:

- President's Committee on Mental Retardation, 1969.
4. International League of Societies for the Mentally Handicapped, pg. 2, 1971.
5. Thorne, G: Understanding the Mentally Retarded. McGraw-Hill Book Company, 1965.
6. State Laws and Regulations Affecting the Mentally Retarded: A Check List, U.S. Department of Health, Education and Welfare, Public Health Service, June 1964.
7. Progress Toward a Free Appropriate Public Education: A Report to Congress on the Implementation of Public Law 94-142, U.S. Department of Health, Education and Welfare, Office of Education, January 1979.
8. James, G: Evaluation in Public Health Practice, Am. J. Public Health, 52, 1145-1154, July 1962.
9. Boggs, E and Henney, L: A Numerical and Functional Description of the Developmentally Disabled Population in the United States by Major Life Activities, EMC Institutes, Philadelphia, Pa., 1979.
10. Proposed Program for National Action to Combat Mental Retardation, Washington, D.C., 1952.

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3. Have you ever been **forced to have sexual activities**? If yes, by whom? Indicate which of the following apply: spouse, ex-spouse, current or former partner, stranger, parent, caregiver, other, multiple.
4. Are you **afraid** of anyone listed above?

KEEPING YOUR PROFESSIONAL RADAR ON

1. **Remember** to screen your patients for violence.
2. **Ask Questions.**
3. **Document** your findings.
4. **Assess** your patient's safety.
5. **Review** options with your patient. Know where to refer.



Physicians and their spouses united to confront family violence
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SOUTH CAROLINA'S LAST YELLOW FEVER EPIDEMIC: MANNING SIMONS AT PORT ROYAL, 1877

ELIZABETH YOUNG NEWSOM*

Dr. Manning Simons of Charleston arrived in Port Royal, South Carolina at 10:30 A.M. on October 2, 1877. He had come in response to a request of the previous day from the mayor of Port Royal to the Medical Society of South Carolina for help in an epidemic. Such requests were common in the 19th century when whole communities were devastated by disease and local medical personnel overwhelmed with their care.

Dr. Simons, an 1868 graduate of the Medical College of the State of South Carolina, in 1877 was Demonstrator of Anatomy at his Alma Mater. He would later become Professor of Clinical Surgery. His recent experience in the 1871 yellow fever outbreak in Charleston guaranteed not only his immunity to the disease but also his first hand knowledge.

Shortly after his arrival in the "unhappy looking country village," Dr. Simons determined that the epidemic was yellow fever and not malaria as had been suspected. Telegrams were sent daily to Dr. J. F. M. Geddings, President of the Society, reporting on the number of new cases and the rate of mortality.¹ The following year, Simons gave a detailed report to the annual meeting of the South Carolina Medical Association. From these two sources several interesting points arise.

Prior to the discovery of the cause of yellow fever, there was much speculation about the possible causative effects of climate, topography, drainage, and cleanliness. Dr. Simons inspected all of these aspects of Port

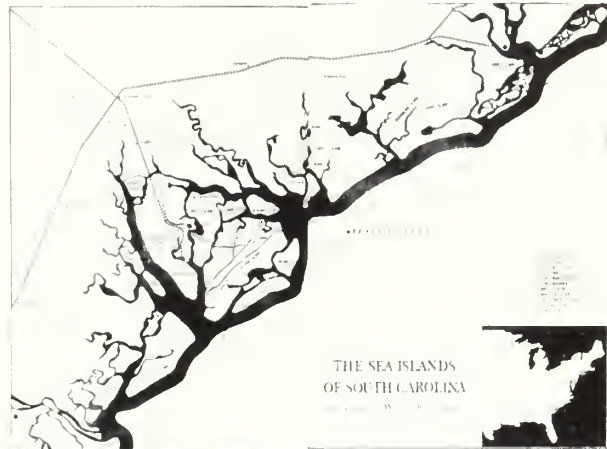


Figure 1.

Royal and pronounced them good. The town was situated on a bluff with good drainage and adequate ventilation. The work of the "energetic Chairman of the corporation Board of Health" was commended: "Even during the existence of the epidemic, car loads of pure sand and gravel were brought from miles away, and all damp places were in this manner filled up."² (p.10)

In the 19th century, yellow fever was often referred to as "stranger's fever" because it was thought that those persons not native to the affected area were much more vulnerable to the disease. In Port Royal, Dr. Simons had the opportunity to observe the ravages of the epidemic in a totally "unacclimated" population. Yellow fever had never before affected the town, and, even more telling: "The place...is inhabited by people collected from all parts of the Northern States and from the interior of the Southern States."² (p.24)

This unusual population for low country South Carolina was the result of the confluence of several circumstances of the Civil War. First, the early fall of the Beaufort/Hilton

*Waring Historical Library, Medical University of South Carolina, 171 Ashley Avenue, Charleston, SC 29425-3001.

Head area (where Port Royal is located, see Figure 1) to the Federal forces left the large slave population on their own as their masters fled. "(On two days the white population vanished, leaving in most cases the colored people in their houses...Five thousand slaves lifted their heads (from chopping cotton) and were free!"^{3 (p.14)}

Second, the "Port Royal Experiment" brought scores of northern missionaries down to educate the slaves and to attempt to harvest the valuable Sea Island cotton crop in the fields. And third, the Act of Congress which had imposed a direct tax on the nation's property to support the war effort, enabled the Port Royal plantations, in the absence of their owners, to be sold for taxes. The buyers were, for the most part, the northern missionaries and entrepreneurs.^{3 (p.227ff)} Although most of the confiscated property in South Carolina was eventually returned to the original owners, that of Port Royal was not.

In previous epidemics of yellow fever, there had been a great deal of controversy as to differential diagnosis with talk of "malarial yellow fever," and "an ephemeral form of fever...which was variously designated as Dengue, Breakbone, 'the prevailing fever,' mild Yellow Fever, and Febricula."^{2 (p.25)} None of these fevers was present in Port Royal. There was malaria, but this was differentiated early with a dose of quinine. If the patient improved, it was malaria; if not, yellow fever. Thus, Dr. Simons had almost laboratory conditions for his observations.

The observations made on the symptoms of yellow fever by Manning Simons in October, 1877 are remarkably similar to those described today. At that time, laboratory diagnosis was far in the future. Dr. Simons, having only a fever thermometer and perhaps a stethoscope in his armamentarium, had to rely on bedside observation. In his discussion of "the phenomena of the urine," he apologized that he was unable to give microscopic examinations, which were impossible "under the exigencies of the service, when every moment was consumed in attention to the

wants of the sick, leaving no time to the pursuit of pathological research."^{2 (p.23)}

Simons' clinical manifestations bear an uncanny resemblance to those of Thomas Monath, M. D. published 100 years later. Dr. Simons describes:

the onset with chill, or sensations of chilliness; the immediately following pain in the head, back and limbs; the rapidly rising fever of intense grade; the red and injected watery eyes; the sluggish capillary circulation; the black vomit; the albuminous urine; the suppression of this secretion; the hemorrhages, and the rapid course of the disease, and the mahogany coloring of the skin.^{2 (p.13)}

Dr. Monath's descriptions are:

patients become icteric...abrupt onset of chills and fever...headache, backache, generalized pain, nausea, and vomiting, a flush face, conjunctival injection, and leukopenia...jaundice, punctate hemorrhages of the soft palate, along with epistaxis, gingival bleeding, and black vomit. Albuminuria and anuria may develop...As many as 50 percent of patients develop Faget's sign. Coma and death occur in about 10-60 percent of patients within 6-8 days.^{4 (p.925)}

Perhaps Simons' most fascinating observation, even though he says that it "has been frequently noted," is the description of the "peculiar inverse ratio of pulse and temperature (Faget's Sign)," one of the definitive diagnostic signs of yellow fever even today. Even though Dr. Faget had made his observation in 1859, (Garrison gives the date as 1875)^{5 (p.636)} there was wide disagreement on it; and it did not seem to be used as a diagnostic tool with any regularity in the "yellow fever belt."

The fever thermometer, invented in the early 17th century, was just coming into general use by practicing physicians in the 1870s. The Medical and Surgical History of the War of the Rebellion, published between 1870-1888, in a long and detailed article on yellow fever, discussed fever but not its relationship to pulse. Dr. Joseph Jones of New Orleans, a

highly respected practitioner and medical scholar and a prolific writer, wrote in 1873 of a "feeble heart" in yellow fever; but it was not until 1890 that he published the following:

(I)n many cases of yellow fever the remarkable phenomenon is witnessed of the pulse progressively decreasing in frequency, and even descending below the normal standard, while the temperature is maintained at an elevated degree.^{6 (p.52)}

On the treatment of yellow fever, Dr. Simons states, "The treatment has had no new light thrown upon it by the experience of this epidemic, except to settle in our mind two points." The first point is the "inutility of the administration of Quinine—nay, more—the absolutely injurious effect that it produced in yellow Fever cases." He elaborates that the drug has no effect on the temperature or the severity of the symptoms and is injurious to the stomach and the nervous system.

The second discovery on treatment and, from the patient's perspective, perhaps the greatest, was "the uselessness and injurious result of application of blisters over the epigastrium." At that time, blisters were used as counterirritants in many diseases. "By exciting a disease artificially on the surface, we can often remove another which may be at the time existing internally." Blisters were produced on the unfortunate sufferer either by heat or Cantharides (Spanish Fly). They were often the sites of hemorrhages and the source of intense pain. Dr. Simons believed that they were harmful to the kidneys as well.^{2 (pp.30-31)}

SUMMARY

Throughout the 19th century, yellow fever was the scourge of southern coastal cities. Because of primitive diagnostic tools, differential diagnosis during epidemics was often difficult. Many patients were diagnosed with "malarial fever," breakbone fever, "the prevailing fever," and "mild yellow fever," to name a few. Dr. Manning Simons's opportunity to study an almost "pure" epidemic of yellow fever among an "unacclimated" population was a breakthrough in diagnostic medicine. Fortunately, his findings were not to be needed again in South Carolina, since this was the last outbreak of yellow fever in the state. □

REFERENCES

1. Telegrams of Dr. Manning Simons to Dr. J. F. M. Geddings, October 3-10, 1977. In manuscript collections of the Waring Historical Library, MUSC, Charleston, SC.
2. Simons, Manning. A note on the epidemic of yellow fever at Port Royal in 1877. *Trans. SCMA*, 1878.
3. Simkins, FB and Woody, RH. *South Carolina During Reconstruction*. Chapel Hill: UNC Press, 1932.
4. Monath, Thomas P. Yellow fever virus. In *Principles and Practice of Infectious Diseases*, ed. Mandell, Douglas, Bennett. New York: John Wiley and Sons, c. 1985.
5. Garrison, Fielding H. *An Introduction to the History of Medicine*. Philadelphia: W. B. Saunders Company, 1929.
6. Jones, Joseph. Outline of the history, theory and practice of quarantine. In *Medical and Surgical Memoirs*, v. 3, New Orleans: Vince Mallum Bono, 1890.
7. Dunglison, Robley. *A Dictionary of Medical Science*. Philadelphia: Henry C. Lea, 1874.

Editorials

Guest editorials reflect the opinions of the authors and do not necessarily represent the opinions or policies of the officers and trustees of the South Carolina Medical Association.

—CSB

MANAGED CARE AND QUALITY CARE: ARE THEY COMPATIBLE?

The current health care environment is extremely uncertain and it is impossible to predict how health care plans, health care delivery, and physicians will be organized and regulated in the next few years. Managed care delivery systems, with their tight organization and vertical structure, are the darlings of governmental planners and Wall Street gurus. At least 75 percent of physicians currently provide care under one or more managed care contracts.

But.... there are clouds on the horizon. Physician ownership of managed care organizations has been steadily declining since the mid 1980s and the justice department and the IRS are using antitrust legislation and tax laws to club individual physicians, physician groups, and physician networks into submission to cash-flush "HMO" organizations. Physician autonomy, both medical and economic, has been tremendously reduced. Clinical guidelines for patient treatment and recovery have been developed not by doctors but by actuarial and consulting firms. Utilization review, practice parameters, restricted provider panels, deselection, and onerous risk-sharing arrangements keep physicians in line. In some organizations it's profit over improved patient prognosis and transfer of wealth from hospitals and physicians to managed care companies and executives. One HMO paid its CEO \$18,671,131 last year! Sure beats checking for hernias!

Organized medicine and physicians as individuals must move to rapidly influence as much as possible and as positively as possible the changes underway in the current medical care revolution. However, influencing change will not be easy and requires action at state, local, and national levels. You can obviously do this by maintaining your membership in your county, state, and national AMA. Furthermore, physicians can transcend the political and economic issues because only they understand real quality medical care. We can take the lead in the scientific assessment of quality standards and continue to provide proper and adequate patient care while retaining the personal and humanitarian side of medicine. The need for expert physician providers and managers will increase rapidly in the years to come and many of you are in responsible positions in your communities and hospitals which will allow you to take this lead. The focus is shifting to overall health and wellness of patients (read beneficiaries or covered lives) rather than treating illness. Who better to know about health and wellness than physicians? Promote your profession and your professionalism, emphasize patient and physician autonomy with choice, champion irrefutable medical ethics, advocate adequate funding for medical science and research, insist on safeguards for the rights of patients and physicians, demand reasonable standards of clinical practice, and campaign

for anti-trust, insurance, and tort liability reform. Finally, keep in touch with your political friends and politicians because your opinions do mean something to them, even if they don't always vote your way.

Don't despair and don't given up as great challenges and great opportunities lie ahead of us. Each of us can make a difference. Maximal flexibility and adaptability on the part of physicians will be required if any of us is to salvage our career much less an adequate

income. Calculated financial decisions do not have to replace outstanding, quality health care rendered by dedicated and devoted professionals.

R. Duren Johnson, M. D.
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800 West Meeting Street
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Letters to the Editor

To the Editor:

I would like to congratulate Dr. Ned Nicholson on assuming the presidency of the SCMA at the Spring Meeting held this past April. His experience, personality and affability will function well in providing leadership and direction to the SCMA for the coming year.

Dr. Nicholson's theme—Physicians and Their Spouses United to Confront Family Violence—certainly is timely, and is just the type of issue which needs public exposure, discussion and resolution.

The Columbia Medical Society ties in strongly with this theme with a program we have been running since October, 1994. Our Community Concerns Committee, co-chaired by Drs. Raymond Bynoe and Frederick Greene, has developed a Youth and Violence Program.

The program involves using our physicians in the local school districts to conduct a program which confronts adolescents and their parents with information regarding the effects of violence on youth in our local community. We utilize current state and local statistics generated by a hospital trauma unit in conjunction with the local police department.

Our program has been received with considerable enthusiasm by the education community, and we have received plenty of assistance by the law enforcement community.

We have not yet assessed the impact of our program on the students, but the participation by our physicians and appeals from parents and educators for more involvement demonstrate the need for us to be a part of the solution. Dr. Deborah Prothrow-Stith, an internist who regards violence as a treatable disease, through the AMA assures us that our kids will consume OUR TIME, OUR MONEY AND OUR RESOURCES. It is a question of whether we will allow it to be early on (preventive) or later (much more costly).

We, the members of the Columbia Medical Society, feel that our program on violence in the schools denotes the type of grassroots effort that enhances the overall efforts of the South Carolina Medical Association. For more information, please contact Marge Ehrenclou, CMS Executive Director (765-1498).

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Columbia Medical Society
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To the Editor:

I am writing in response to the letter from William H. Hunter, M. D., (May, 1995 issue of *The Journal*) concerning psychiatric diagnosis. He stated that a diagnosis of depression "sometimes causes the patients problems with insurance," and suggested several diagnostic codes to use for patients with depression. I am concerned about inaccuracies in Dr. Hunter's suggestions, and with what seems to be an implicit assumption that psychiatric diagnosis is so vague and arbitrary that there is no need for diagnostic precision. From 1980, when DSM-III was published, through the present, with DSM-IV,¹ psychiatric diagnosis has been based upon specific, observable criteria, and the reliability of psychiatric diagnoses compares quite favorably with that of the rest of medicine.

While Dysthymia is, as Dr. Hunter correctly notes, coded 300.4, "depressed several weeks" is an inadequate descriptor. Patients with Major depressive disorder (single episode or recurrent, and with or without psychotic features), Bipolar I disorder, Bipolar II disorder, Cyclothymic disorder, Substance-induced mood disorder, and various Adjustment disorders, among others, could all be depressed "for several weeks." For some of these patients, antidepressants might be indicated, whereas for others they might be contraindicated. The hallmark of Dysthymic disorder is a predominantly depressed mood for two years, along with other specific inclusion criteria in the absence of still other specific exclusion criteria. Because 300.4 is the code for Dysthymic disorder, it cannot also be the code for "Major depression (borderline psychotic);" furthermore, while Major depression may be sufficiently severe to include psychotic features, the term "borderline psychotic" is not used in describing mood disorders. Also, 309.0 is Adjustment disorder with depressed mood (not "Adjustment disorder (re: specific problems)"), and 296.2 is Major depression, single episode, not "Recurrent major depression." One of the five items—Adjustment disorder with mixed anxiety and

depressed mood—is coded correctly. These are not merely statistical quibbles, but rather reflect the need to clearly distinguish among disorders with a broad spectrum of severities, widely varying courses over time, and distinctly different treatments. Making a psychiatric diagnosis requires knowledge of many more specific factors than Dr. Hunter's guidelines seem to suggest; it seems especially unfortunate to espouse a casual approach to diagnosis when instruments are now available that allow primary care physicians to make acceptably accurate psychiatric diagnoses with relatively little expenditure of time.^{2,3} To what degree primary physicians should treat, as well as diagnose, psychiatric patients is a separate issue: while some non-psychiatric physicians may provide excellent treatment for some depressed patients, recent evidence suggests that underutilization of psychiatric expertise saves a little money at the cost of poorer patient outcome.⁴

Surely some of the "problems with insurance" mentioned by Dr. Hunter reflect insurers' continuing prejudice against patients with psychiatric illnesses, even when those illnesses are strongly "biologically" (as opposed to purely "psychologically") based. We should not add to our patients' troubles by supplying insurers with diagnostic codes that are misleading or clearly wrong.

Thomas E. Steele, M. D.
57 Smith Street
Charleston, SC 29401

REFERENCES

1. Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition). Washington, DC: American Psychiatric Association, 1994.
2. Spitzer RL, Williams JB, Kroenke K, Linzer M, deGruy FV, Hahn SR, Brody D, Johnson JG: Utility of a new procedure for diagnosing mental disorders in primary care: The PRIME-MD 1000 study. *JAMA* 272:1749-1756, 1994.
3. Kroenke K, Spitzer RL, Williams JB, Linzer M, Hahn SR, deGruy FV, Brody D: Physical symptoms in primary care: Predictors of psychiatric disorders and functional impairment. *Arch Fam Medicine* 3:774-779, 1994.
4. Sturm R, Wells KB: How can care for depression become more cost-effective? *JAMA* 273:51-58, 1995.

In response:

Mea culpa! Dr. Hunter's letter was meant to be a practical suggestion for busy primary care physicians. I took the liberty to condense his submission. From my own association with Dr. Hunter, I can assure Dr. Steele that Dr. Hunter's respect for psychiatry and for the intricacies of psychiatric diagnosis. Indeed, in these and in so many other respects, he sets a very high standard for the rest of us!

On the other hand, the problem that Dr.

Hunter addresses is, in my opinion, both real and valid. My experience has been that while psychiatric diagnoses can sometimes be made in a time-efficient manner (as Dr. Steele suggests), appropriate care of these patients requires considerable expenditure of time. Non-reimbursement therefore becomes a major issue. All of us should work together toward rectifying this generic issue.

—CSB

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On the Cover:

ESTIENNE'S *DE DISSECTIONE*

Charles Estienne's *De Dissectione Partium Corporis Humani Libri Tres* (Concerning the Dissection of Parts of the Human Body, in Three books) was given to the Library of the Medical University of South Carolina in 1975 by the College of Dentistry in memory of Dr. James W. Colbert, Jr.¹ It was the 100,000th volume in the library.

Published 450 years ago, in 1545, *De Dissectione* has been described as second only to the *Fabrica* of Vesalius in sixteenth century anatomic illustration. It contains 62 fine, full page anatomical woodcuts done by three artists. Because the work was 15 years in preparation and relied heavily on the Galenic tradition, it was considered out of date before publication, having been preempted by the *Fabrica* in 1543.

The information on Estienne's life (c. 1505-1564) is sketchy but intriguing. He was a physician from a family of prominent French publishers who eventually gave up the practice of medicine to take over the family business. His firm was, for a time, printer to the King of France and issued books on a wide range of scholarly subjects, one of which was dedicated to the Inquisitor Guillaume de Bail-

ly. This was perhaps politic since Estienne's brother, Robert, had been accused of "protestantism" and forced to seek asylum in Geneva. Charles was the author of several books on gardening, diet and anatomy.

While working on *De Dissectione* with Estienne de la Riviere, a surgeon who made the dissections and helped with the illustrations, Estienne was sued by Riviere to assure that his (Riviere's) efforts would get due recognition. The case delayed publication of the book for six years and resulted in a rather strange title containing the names of both men.

Charles Estienne proved to be a poor businessman. Accused of having squandered the family fortune, in 1561 he was arrested either for heresy or for bad debts and died in a Paris prison in 1564.

Betty Newsom

The Waring Historical Library

REFERENCE

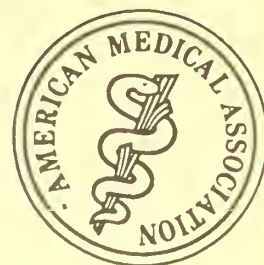
1. Dr. Colbert, Vice President for Academic Affairs at MUSC, was killed in a plane crash on Wednesday, September 11, 1974. During his five-year tenure, Dr. Colbert played a major role in the development of the statewide system of health education and in the unparalleled growth of the university.



THE ANNUAL MEETING OF THE AMA CHICAGO, ILLINOIS – JUNE 18-22, 1995

REPORT OF THE SCMA DELEGATION

WALTER J. ROBERTS, JR., M. D.*



The annual meeting of the American Medical Association was held in Chicago, Illinois, June 18-22, 1995. In addition to the delegation to the meeting, South Carolina was represented by SCMA President Ned Nicholson and President-elect Carol Nichols. Chief Executive Officer Bill Mahon and Senior Vice President and Legal Counsel Steve Williams were also in attendance. South Carolina's member of the AMA Board of Trustees, Randy Smoak, adds strength and knowledge to our delegation, and this year, Dr. Ed Kimbrough further strengthens our representation as delegate from the American Orthopedic Association. This is a high and richly deserved honor accorded Dr. Kimbrough by his specialty association, and our delegation welcomes him. He will be, we are sure, a major force in our national presence.

I must also mention the presence at the meeting of many of the wives, since they contribute greatly to delegation activities. Fran Hawk, Beth Gaddy, Patsy Simmons, Suzanne Weston, Kitty Nicholson, Debbie Burton, Nancy Roberts and Diane Williams must be thanked for all their help, especially during meetings when we are involved in an election, as will be discussed below.

We were honored at this meeting by the appointment of Chris Hawk as Chairman of the Reference Committee on Amendments to

Constitution and Bylaws. Reference committees, which perform much of the work of the House of Delegates, are appointed by the Speaker of the House, and such designation to a committee is considered by everyone to reflect upon the ability of the individual and the delegation from which he comes. For the past three years, South Carolina has been represented on these committees.

As mentioned above, Dr. Randy Smoak was up for reelection to the AMA Board of Trustees, Randy having served his first three-year term. I am happy to report that he was reelected, without opposition, to this high office. It should also be recognized that Randy is rapidly advancing in prominence on the board, having been elected by the board members as the At-large Member of the Executive Committee of the Board, and serving in the important job as Chairman of the Finance Committee of the Board.

In addition, our CEO, Bill Mahon, was accorded the great honor of being elected an affiliate member of the AMA. This is a reflection of the high esteem in which he is held by the AMA; we at SCMA recognize that Bill is among the best, if not the best, of state executives, and we feel the award is richly deserved.

As might be easily imagined, in this time of much change in the profession of medicine, the issues raised and discussed at the meeting are many and varied, and the questions raised

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often answered by replies which are controversial and incomplete. I can only assure you that hours and hours of careful deliberation and hours and hours of thoughtful discussion by many dedicated and capable physicians go into the reports and resolutions which come out of the house of delegates of the AMA.

Two issues stand out as paramount as I relate to you, our membership, those deliberations and discussions: (1) the restructuring of Medicare, and (2) the problems surrounding Managed Care, as it is being thrust upon the patients and physicians of our country. The latter issue has become so complex and divisive as it increases its "penetration" that it would require many, many reports such as this, so I will endeavor to touch upon only one or two of the most confounding of its complexities, especially upon "Point of Service" contracting, and the ethical issues which pervade this new method of delivering medical care.

MEDICARE TRANSFORMATION: CURRENT STATUS

Since it seems clear that there shall be changes in the Medicare program, AMA's Board and House have been greatly involved in developing ideas about how these changes should be made. There exists in the minds of our AMA leadership that the current Congress, as exemplified by Speaker Gingrich, will be responsive to those suggestions offered by organized medicine, where the "Health Reform" initiatives of Mrs. Clinton and Mr. Magaziner seemed determined to exclude physicians from any meaningful input.

The AMA's Board prepared a report on the issue which recommends that the fundamental goal of any change in Medicare

should remain high quality and accessible health care for the elderly, and that best value can be achieved by involving the medical profession in the design and implementation of such a program. Further, the statement suggests that in the changes directed toward enhancing fiscal solvency, there needs to be an option for Medicare recipients to access private health care coverage, with a defined contribution by the Federal Government equal to an actuarially established value of the contribution the "traditional" Medicare patient receives. It is felt by AMA that this will improve fiscal solvency of the Medicare program, and allow those patients who can afford and who desire private care to avail themselves of such care.

The report further states that AMA policy should include approaches which restructure Medicare beneficiary deductibles and coinsurance while increasing patient choice and maintaining beneficiary protection in Medigap coverage. Incentives should be in place which encourage patients to seek out "preventive services" in this effort to improve the fiscal solvency.

Further, and even more in depth, policy recommendations refer to issues such as RBRVS conversion factor establishment, reduction in Medicare funding of residency programs, and protection of physicians in negotiations with health care plans, since anti-trust violations remain a concern.

The policy statement, which is Board of Trustees Report 44-A-95, is expansive, far-reaching in its scope and worthy of your reading in its entirety. It is also timely, since written in response to requests from Congress and from the Administration for elaboration of AMA policy. We can only hope much of what comes out of the current plans for Medicare change incorporates the report's suggestions. Speaker Gingrich did appear, via

TV satellite hook-up, at the meeting. He discussed his plans for Medicare changes, indicating there will be proposed a "menu" of perhaps seven alternatives offered Medicare recipients, included in which will be options for access to fee-for-service medicine where Medicare funds may be used by the recipient, probably in the form of a voucher. Managed care options through HMOs are also prominently mentioned among the plans.

MANAGED CARE: "POINT OF SERVICE"

Even the most staunch defenders of conventional, fee-for-service medicine now concede that there is an inexorable movement in the country toward "managed care." The concern in all of us should be, first, that quality care of our patients not be sacrificed in the name of cost savings. This is the basic premise of the Patient's Protection Act, advanced through Congress by AMA, fought at the national level by the insurance industry, Chambers of Commerce, labor unions and others.

The issue of Point of Service contracting in managed care has stimulated much debate. Proponents avow that such contracts allow the patient member of the HMO or PPO to select his own physician, a situation we all would seem to desire. Opponents of such contracts cite the increased expense to the patient and to the plan in which the patient is enrolled, and the lack of control over utilization and quality of care which will occur.

Several resolutions were brought to the House of Delegates which advocated "mandating" point of service benefits in any and all managed care contracts. This idea was defeated, the House instead advocating the "offering" in all plans of Point of Service,

with the suggestion that any additional expense to the patient and to the managed care entity be nominal. AMA policy has always referred to "pluralistic" approaches to the provision of health care, and the idea of "mandates" is abhorrent to many. Further, it must be realized that a huge segment of physicians over the country now derive the major part of their income from managed care contracts, and the financial viability of those contracts is quite important to those physicians.

It is clear that physicians will support managed care, as long as they are treated fairly. The use by the managed care entity of unilateral decisions which adversely affect physicians is increasingly common as competition among managed care plans becomes more intense.

OTHER ITEMS OF BUSINESS

Numerous other items of business were discussed which bear heavily on all physicians in this time of change:

- A long-standing law called the McCarran-Ferguson Act allows the insurance industry to negotiate fees and charges where physicians cannot, the so-called "un-level playing field" protected by anti-trust laws. AMA is working for repeal.
- Continued efforts are being made to repeal CLIA, and there is now some genuine hope of success. Other similar proposals have been advanced to repeal OSHA, but it is clear that what we need to strive to achieve is intelligent and meaningful OSHA regulations, as opposed to many of the current regulations which seem designed to irritate physicians, and cause them to

spend time and money needlessly.

- AMA must seek to preserve the "safety net" of Medicaid for truly indigent patients, which many feel may be threatened by distribution of money to the states through "Block Grants."
- There is concern in some that federal initiative toward tort reform for medical liability may preempt some states' more desirable, existing laws. These states want protection against such invasion.
- Some feel that health plans heretofore protected by ERISA regulations should be required to provide certain services such as immunizations. This might lead to changes in ERISA laws.
- Alternatives must be sought for credentialing and certifying physicians. Such certification is increasingly important because of managed care qualifications, but is costly to the physician, often capricious in testing and certifying. AMA and the American Board of Medical Specialists (ABMS) are seeking some solutions.
- In this era of increasing utilization of non-MD personnel such as Physician Assistants and Nurse Practitioners, AMA

policy must continue to reinforce the premise that the physician be responsible in supervising and in designing protocols.

Since it appears unerringly true that the insurance industry and entrepreneurs in providing managed care plans are reaping huge benefits, is it most reasonable to require them—at least encourage them—to pay part of the bills for medical education? Also, if everyone is getting "managed care," what about our reported 37 million uninsured or underinsured people? Shouldn't some help come from the "managed care" industry for them?

I am certain that I have not touched upon many important issues and once more I recommend your reading the actions of the AMA House of Delegates which will be reported in *AM News* and elsewhere. Please understand that your South Carolina AMA delegation is a dedicated and visible one, that we are working for what we feel to be the best interests of South Carolina physicians at the national level. If you have an idea or a problem which you feel should be brought to the AMA, let your SC delegation hear from you. We appreciate the opportunity to serve you and to serve our patients who continue, as always, to be our greatest concern. □



Alliance Page

MY ALLIANCE WITH THE CLASS OF 1970

Last weekend, my husband and I joined his MUSC classmates and their families for their 25th reunion celebration. In his class of 81 students, three were female, and 25 were married. All of us, students and spouses, worked full or part-time, sometimes three jobs, to get to graduation four years later. We were a team. I grew close to our spouses group in WASAMA. Throughout Vasa's post-graduate training years in the Navy, I joined other physician's wives clubs. In 1980, in private practice, my membership in this medical auxiliary began. Membership in the Lexington County, SCMA, AMA Auxiliaries gave me a variety of opportunities for personal growth and support of medicine, our community, friends and family:

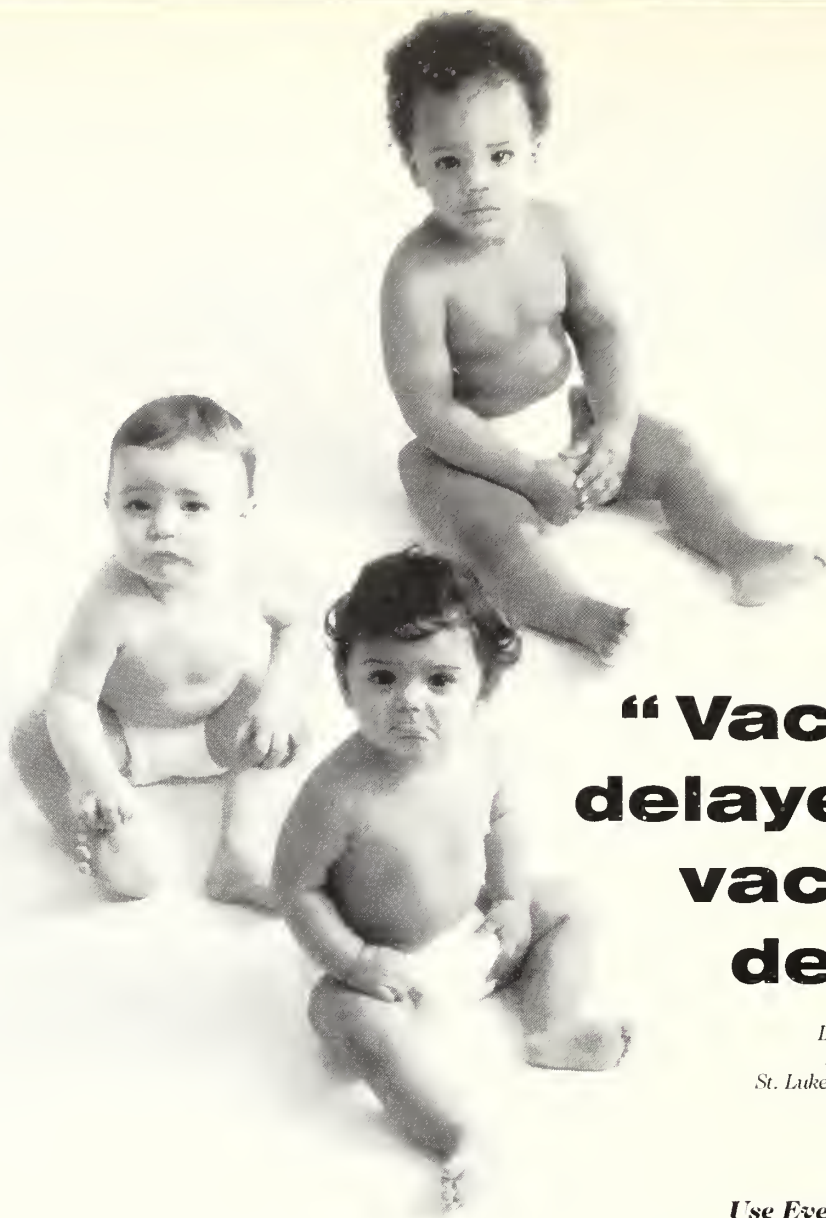
- * AMA-ERF — 24 counties and state raffle raised \$35,000 for medical education.
- * County health projects and scholarships — Annual fundraising up to \$25,000 in many counties across the state.
- * Joint projects with SCMA — Health Education Van and SAVE — "Stop America's Violence Everywhere"

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Gray Matter

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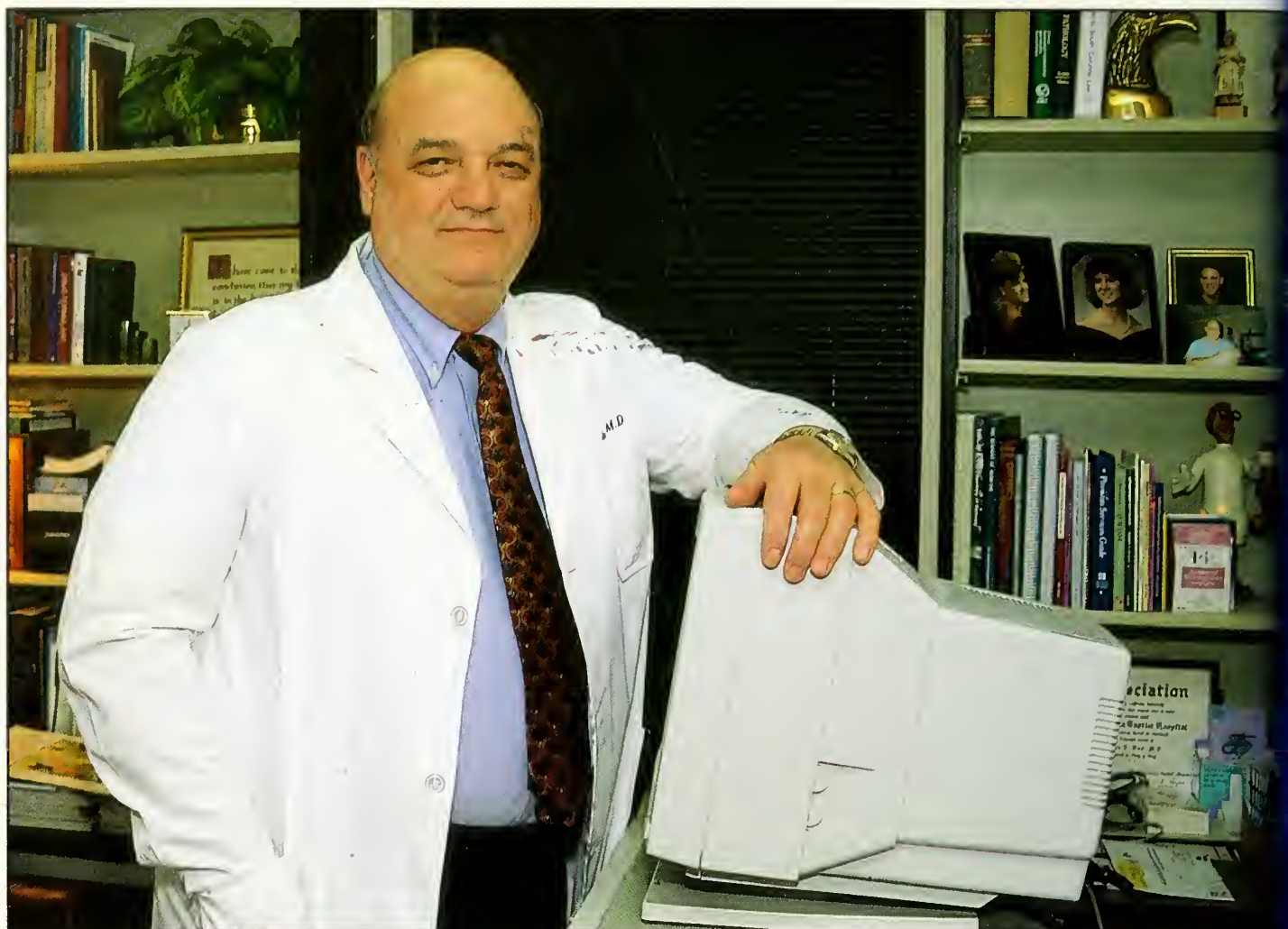
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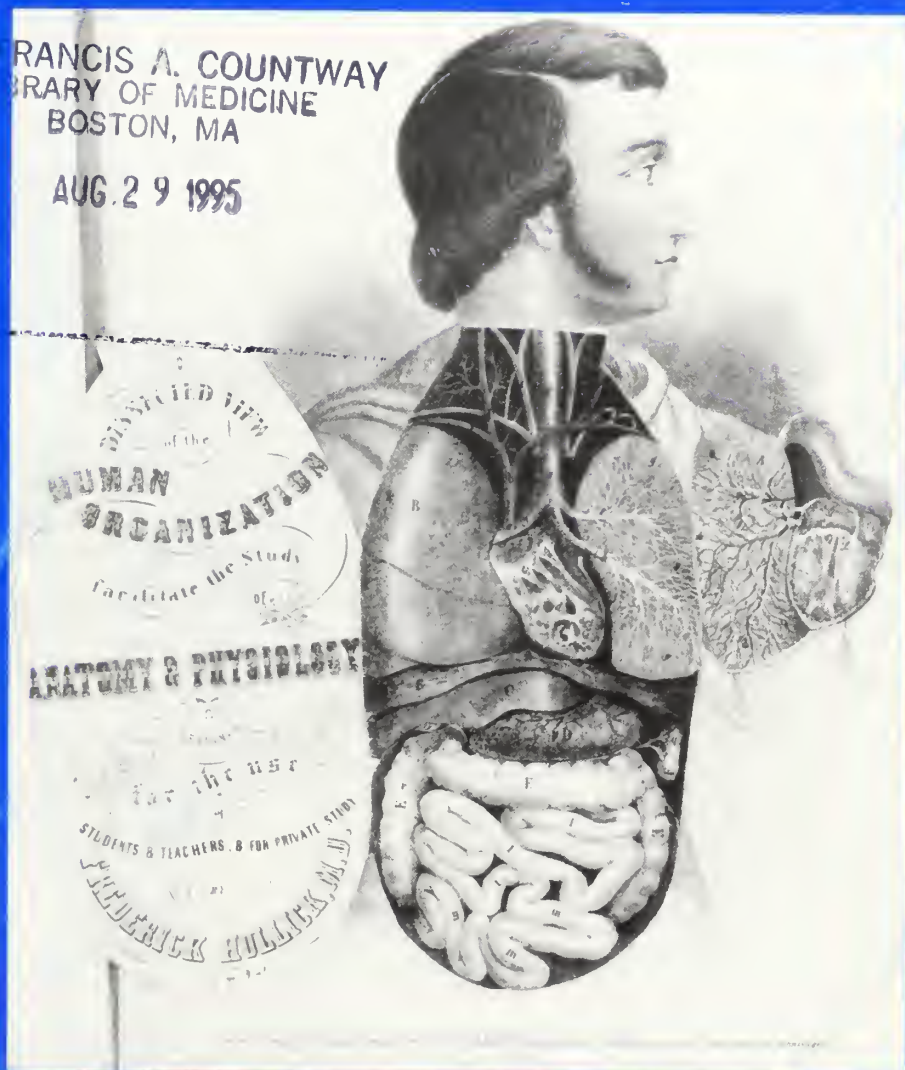


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FETAL ECHOCARDIOGRAPHY
VASECTOMY REVERSAL
LITHOTRIPSY FOR STAGHORN CALCULI
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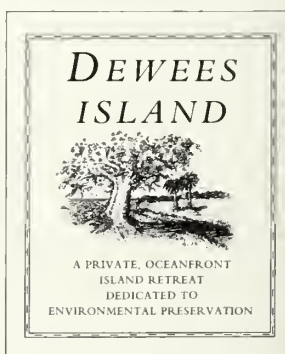
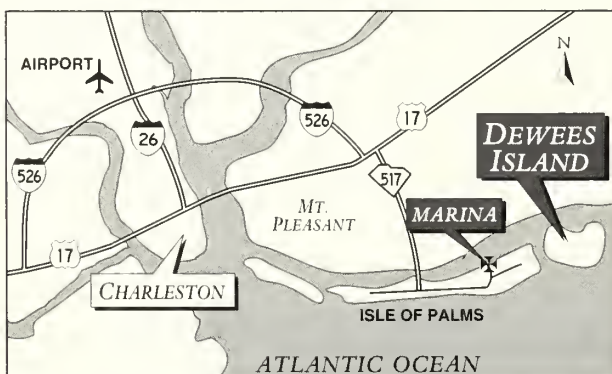
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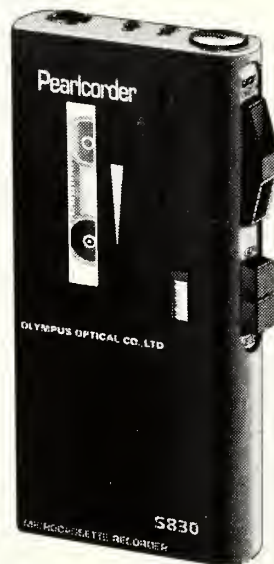
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President's Page

MANAGED CARE QUESTIONS

In my June President's Page in *The Journal*, I discussed problems that I have encountered with managed care plans. I have received several responses from around the state which have encouraged me to write more on the subject. Physicians should investigate a plan before signing a contract. Questions to ask are:

- Who owns the plan? Are physicians represented in its governing board?
- Is the plan operating profitably? Ask for a financial statement.
- Does the plan maintain solvency insurance? If so, will it cover physician claims?
- Is the plan properly licensed in SC? HMOs are required to be licensed. PPOs are not.
- Who are participating physicians and hospitals? How often is the list updated?
- Does the plan intend to contract with competing physicians?
- What is the current number of enrollees?
- What is the plan's history of returning withhold amounts?
- Which employers are offering the plan?
- Ask for a sample of the plan's explanation of benefits which should show the amount charged, the amount allowed, co-payment, and deductible.
- On what basis does the plan pay? Discounted fee for service? UCR? RBRVS or capitation? How does the plan calculate this?
- Is there training for the office staff?
- If the physician has a CLIA approved lab, will the plan pay, or will lab work have to be referred out?
- Is there a toll-free number to call for verification of benefits or problems?
- What will the plan pay for the physician's 20 most frequent services by CPT code?

Answers to these questions should give you a good overview of the plan and should be given in writing. In addition, you must read your contract thoroughly and attempt to negotiate undesirable clauses, such as "most favored nation" clauses and termination of contract without cause clauses. A physician's right to terminate the contract must be spelled out. Negotiations are more successful if you are needed by the plan in your geographic areas, or if you negotiate as part of a group.

Capitation plans will become more common in the next few years and present many pitfalls for the physician. You must know how much it costs to deliver a service, or you may lose money. You must know whether you assume full risk or have a shared risk contract. You must know the number of enrollees you will have and their ages and sex, as older patients may use more services and young females will use more obstetrical services. The plan must provide "stop-loss insurance." Without it, several very sick patients may eat up your entire year's profits. You probably cannot negotiate fees, as plans like to keep these at their standard rate, but you may be able to negotiate concessions such as fee for service until you build up enough enrollees to make capitation work in your practice.

Physicians, educate thyselfs.

A handwritten signature in cursive script that reads "Ned Nicholson".

Benjamin E. Nicholson, M. D.
President

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FETAL ECHOCARDIOGRAPHY: A REVIEW OF 1,028 CONSECUTIVE EXAMINATIONS*

DIANE KOEHLER, R. D. C. S.
KARLA B. MEYER, R. D. C. S.
CHARLES H. KLINE, R. D. M. S.
DEREK A. FYFE, M. D., PH. D.**

In October 1984, a program of fetal echocardiography was begun at the Medical University of South Carolina. We published our initial experience in July 1987 with 100 cases.¹ Since that time, fetal echocardiography has become more widely known as a diagnostic discipline, and more widely accepted amongst obstetricians and perinatologists as a useful asset in patient care.² Additionally, with improvements and technology, more detailed examinations, including two-dimensional and color Doppler flow studies, can be performed.³

To examine the utility of this technique in a large group of patients and to delineate our spectrum in diagnoses, we report our experience over the last four and a half years of 1,028 consecutive fetal echocardiograms.

MATERIALS AND METHODS

From January, 1990 to June, 1994, all cases of

fetal echocardiography performed at the Medical University of South Carolina, Division of Pediatric Cardiology, were reviewed. Examinations were performed using various ultrasound machines (Acuson XP 128, Interspec Apogee CX 200, and ATL Ultramark 9). Examinations were performed with 3, 5 or 7.5 mHz transducers. In each case, a brief examination with color flow Doppler echocardiography was performed to demonstrate patency and competence of cardiac valves and vessels. M-mode examinations were done in patients in whom fetal arrhythmia characterization was required.

RESULTS

The data were reviewed by referral diagnosis (Table 1).

There were 263 (25.6%) referrals because of an abnormal obstetric ultrasound examination in which either hydrops fetalis, a two-vessel umbilical cord, pericardial effusion and/or an apparently abnormal heart structure was seen. The cardiac defects diagnosed are listed in Table 2 and occurred in 20 percent of

*From the South Carolina Children's Heart Center, Medical University of South Carolina, Charleston, SC.

**Address correspondence to Dr. Fyfe at The Children's Heart Center, Emory University, 2040 Ridgewood Drive, NE, Atlanta, GA 30322.

TABLE 1
Fetal Cardiac Referrals (1,028)
Indications for Cardiac Study

Abnormal OB scan	263
Family hx of CHD	229
Maternal illness	190
Fetal arrhythmia	177
Preterm labor	120
Maternal drug usage	49

these referrals.

The second most common referral was due to a family history of congenital heart disease in 229 (22.3%), e. g., a mother, father or sibling who had congenital heart disease. Only four of these cases were abnormal, including one ventricular septal defect, one atrioventricular septal defect, one with tetralogy of Fallot, and one patient with premature atrial contractions, giving 1.7 percent of these referrals as abnormal.

Maternal illnesses, including patients with diabetes mellitus, systemic lupus erythematosus, or a preceding viral illness, were the reason seen in 190 (18.5%) of referrals, and six of these were abnormal, including one transposition of the great vessels with pulmonary stenosis, two single ventricles, one of whom had a hypoplastic aorta, one atrioventricular septal defect, one mass within a papillary muscle, and one patient with premature atrial contractions.

There were 177 (17.2%) patients referred for suspected fetal arrhythmias, 43.5 percent of whom were found to have arrhythmias at the time of the examination and the mechanism of the arrhythmia was characterized by fetal echocardiography (Table 3).

Sixty-four patients had conducted or non-conducted premature atrial contractions (PAC), five had sustained supraventricular tachycardia (SVT), two had sustained bradycardia, two had atrial flutter with variable atrioventricular conduction, one had bigeminal premature atrial contractions, one had complete heart block with ventricular rate of 50 beats per minute, one had sinus bradycardia, one had two-to-one atrioventricular

TABLE 2
ABNORMAL OB SCAN

Tumors/masses	11
Atrioventricular septal defect	10
Right ventricular enlargement	9
Pericardial effusion	6
Hypoplastic left heart	5
Single ventricle	4
Tetralogy of Fallot	2
Transposition of great arteries	1
Right ventricular diverticulum	1
Tricuspid atresia	1
Pulmonary atresia	1

block, and 1 had premature ventricular contractions (PVC). Two had structural heart disease.

One hundred twenty patients (11.7%) were referred while being treated to interrupt preterm labor with either indomethacin or terbutaline. Of these, 36 percent all of whom were taking indomethacin, were abnormal. Thirty-one patients had significant restriction of the ductus arteriosus with diastolic ductal velocity of greater than 40 cm/sec, and this was associated with tricuspid regurgitation due to dilatation of the right ventricle in six cases. All stenotic ductuses returned to normal with diastolic velocities of less than 30 cm/sec when treatment was discontinued for two or three days. Other findings were one patient with an isolated pericardial effusion, one patient with ascites, one patient with premature atrial contractions, and one patient was noted to have an atrioventricular septal defect.

Of 49 patients referred for other forms of maternal drug exposure, i.e. with lithium and

TABLE 3
ARRHYTHMIA

PAC/PVC	64
SVT	5
Bradycardia	2
Atrial bigeminy	2
Atrial flutter*	2
CHB	1
2:1 AV block	1
Tetralogy with PACs	1
Truncus (with atrial flutter)	1

dilantin being the most common drugs, only one abnormal finding of a calcified papillary muscle was detected.

A summary of all congenital heart defects found during this period is shown in Table 4.

DISCUSSION

The widespread acceptance of the utility of fetal echocardiography is validated by the fact that over 1,000 patients have been referred for specific fetal cardiac examinations during this last four and a half years. Referrals were made by obstetricians, perinatologists, pediatricians, family practitioners, and pediatric cardiologists, all of whom were aware of the risk factors which are known to be associated with congenital heart disease.^{3,4} In our study, the highest frequency of detection of cardiac defects was amongst those patients in whom an obstetric ultrasound had been performed and had been noted to be abnormal. As in previously published works, the detection of an asymmetrical or abnormal appearing heart, i.e., a four-chamber view in which either an abnormal number of chambers is seen or size disproportion of the chambers is detected, gives a reliable sign that heart disease is present. Copel et al.⁵ have published that 90 percent of cardiac defects may be detected in this way. An additional screening evaluation employs the evaluation of the great arteries vessels, as the pulmonary artery and aorta "crisscross" in position as one scans from anterior to posterior. In this way, the obstetrician ultrasonographer merely scans from the four-chamber view, anteriorly or posteriorly, gradually displaying first the aorta and then the pulmonary artery, and shows them to be of almost equal size, and that their relationship to each other is normal. This scan allows the determination that both of the great vessels are present; that the proportionate size of each is normal, that is, the pulmonary artery diameter is 20 percent greater than the aorta; that the relationship of the great vessels is not parallel, as is seen in transposition; and that the septum below the great vessels is intact.

TABLE 4
CONGENITAL HEART DEFECTS

Tumors/Masses	11
Atrioventricular septal defect	12
Single ventricle	6
Hypoplastic left ventricle	5
Tetralogy of Fallot	4
Transposition (VSD 1)	2
Truncus arteriosus	1
Pulmonary atresia	1
VSD	1
RV diverticulum	1
Tricuspid atresia	1

The presence of virtually all forms of congenital heart disease can be ruled out with a high-fidelity imaging technique. The widespread use of cardiac screening in this way can potentially detect the majority of heart disease in the larger population who are not known to be at high risk. For all birth defects, cardiac abnormalities are the most frequent. It would seem, therefore, incumbent upon all involved in prenatal imaging that during the ultrasonic evaluation of the fetus a screening examination of the heart should be included in the general population. The majority of patients born with congenital heart disease do not, in fact, have any risk factors. Sharland et al.⁶ have shown in a large population that when obstetric ultrasonographers include the cardiac scans in their examination, this has a profound impact on the detection rate of congenital heart disease in the general population before birth.^{2,6}

The second most common group of our referrals was for fetal arrhythmias. The presence of single frequent premature atrial contractions was the most common and is fortunately seldom accompanied with a structural heart disease or persistent arrhythmia.^{7,8} Rarely, in about one percent of cases of premature atrial contractions, supraventricular ventricular tachycardia supervenes. An appropriate screening would be for the obstetricians to document at follow-up visits whether the heart rate is normal, and whether premature atrial contractions are detected. This can be done by simple heart-rate screen-

ing techniques in obstetric offices.

Fetal echocardiographic monitoring during the administration of tocolytic agents to prevent premature birth is an important issue. As shown in this study and in other studies published by Huhta, et al.,⁹ and recently in South Carolina by Bivins, et al.,¹⁰ 27 percent of patients receiving indomethacin will demonstrate significant adverse effects to the fetal ductus to that achieved by administration of indomethacin to premature babies, and 38 percent developed oligohydramnios. The administration of indomethacin in utero has a similar effect, causing ductal closure, which results in pulmonary hypotension in the fetus, right-heart failure with dilatation and poor right ventricular function. Additionally, tricuspid regurgitation occurs and can lead to hydrops fetalis. The effects of the administration of prostaglandin inhibited drugs to the newborn can be that babies are born with pulmonary hypertension, which can be fatal. In our practice we have seen several children born with persistent pulmonary hypertension and a restrictive ductus arteriosus.

There was a relatively low yield of detection of abnormalities in mothers exposed to other drugs, such as street drugs or therapeutic medications for seizures. This does not obviate the need for screening, at least by an obstetric ultrasonographer familiar with the basic heart structures. Use of lithium for bipolar depressive disorder has been associated with Ebstein's malformation, which can be fatal in severe cases in the newborn period.¹¹

The incidence of congenital heart disease in offspring of parents who themselves have congenital heart disease is documented to be somewhere between 1.4 percent and three percent.^{3,4} In our experience, however, screening first-degree relatives of affected children has had a relatively low yield. Importantly, even though the frequency of malformations is low, the benefits to the family are highly significant. If a mother has had a previous

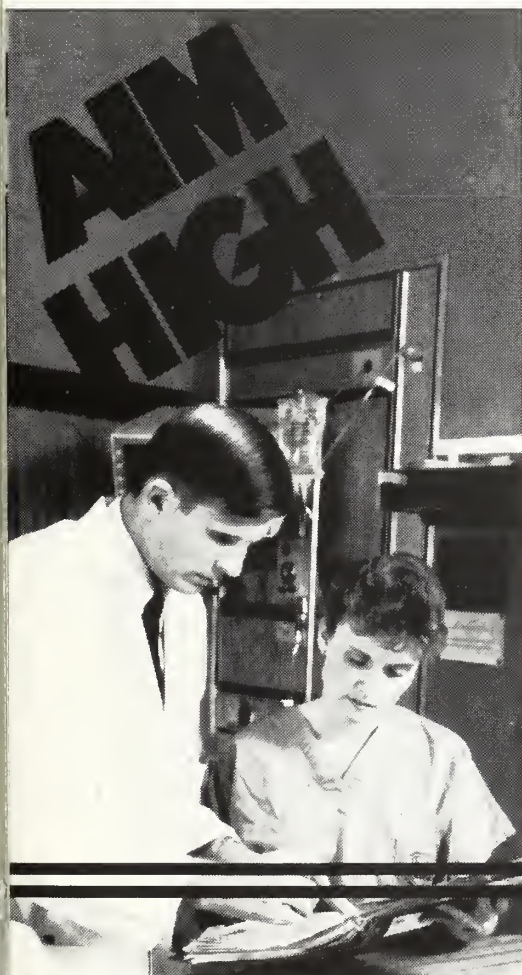
child with hypoplastic left heart syndrome and who has died, the reassurance that the heart has four chambers, two great vessels and that flow through each valve is normal, allows them to continue the pregnancy without the desperate and sometimes incapacitating anxiety associated with the concern of catastrophic heart disease being present. In our experience, the emotional outpourings on informing a family that their baby's heart is normal have been dramatic. There is no question, the psychological benefit to all family members of this kind of study.

In families where fetal heart disease was detected, the majority were delivered at a tertiary care center. This enables the obstetricians to plan the delivery in an appropriate manner for the heart disease present, the perinatologist had been at the delivery to administer appropriate intensive care, the cardiologists have been immediately consulted and instituted prostaglandin therapy and ventilator support, when necessary, and the surgeons had been available to perform emergency or semi emergency procedures, when needed. The ravages of the expression of the serious congenital heart disease have been avoided in many of these patients. The benefit of this is that children do not go home with undetected heart disease and then, on closure of the ductus arteriosus, develop profound heart failure with its accompanying ischemia to the bowel, kidneys and brain. We are able to salvage babies in much better condition and provide the surgical care without delay, rather than having an intensive period of recovery from a critical heart failure which may, or may not, be successful.

In summary, the experience of the last four and a half years in 1,028 patients with examination for fetal heart disease has been extremely rewarding, and has been a major improvement in the quality of care to the families of South Carolina. □

REFERENCES

1. Hammil WW, Fyfe DA, Lowrey CL, Horger EO, Van Dorsten JP, Kline CH. Fetal echocardiography: initial experience with 100 cases. *J SC Med Assoc*; 83:363-7, 1987.
2. Allan LD, Sharland GK, Milburn A, Lockhart SM, Groves AMM, Anderson FH, Cook AC, Fagg NLK. Prospective diagnosis of 1006 consecutive cases of congenital heart disease in the fetus. *J Am Coll Cardiol*; 23:1452-8, 1994.
3. Fyfe DA, Kline CH. Fetal echocardiographic diagnosis of congenital heart disease. *Pediatr Clin North Am*; 37:45-67, 1990.
4. Friedman AH, Copel JA, Kleinman CS. Fetal echocardiography and fetal cardiology: indications, diagnosis and management. *Semin Perinatol*; 17:76-88, 1993.
5. Copel JA, Pilu G, Kleinman CS. Congenital heart disease and extracardiac anomalies: associations and indications for fetal echocardiography. *Am J Obstet Gynecol*; 154:1121-32, 1986.
6. Sharland GK, Allan LD. Screening for congenital heart disease prenatally. Results of a 2 and 1/2 year study in the South East Thames region. *Br J Obstet Gynaecol*; 99:220-5, 1992.
7. Strasburger JF, Huhta JC, Carpenter RJ, et al. Doppler echocardiography in the diagnosis and management of persistent fetal arrhythmias. *J Am Coll Cardiol*; 7:1386, 1986.
8. Rice MJ, McDonald RW, Reller MD. Fetal atrial septal aneurysm: a cause of fetal atrial arrhythmias. *J Am Coll Cardiol*; 12:1292, 1988.
9. Huhta JC, Moise KJ, Fisher DJ, et al. Detection and quantitation of constriction of the fetal ductus arteriosus by Doppler echocardiography. *Circulation*; 75:406, 1987.
10. Bivins HA Jr, Newman RB, Fyfe DA, Campbell BA, Stramm SL. Randomized trial of oral indomethacin and terbutaline sulfate for the long-term suppression of preterm labor. *Am J Obstet Gynecol*; 166:1065-70, 1993.
11. Sharf M, Abinader EG, Shapiro I, et al. Prenatal echocardiographic diagnosis of Ebstein's anomaly with pulmonary atresia. *Am J Obstet Gynecol*; 147:300, 1983.



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VASECTOMY REVERSAL (VASOVASOSTOMY)

FLETCHER C. DERRICK, JR., M. D.*

RAYMOND ROSENBLUM, M. D.

IAN Y. MARSHALL, M. D.

ELIZABETH W. WINGATE, M. D.

In 1948, O'Connor,¹ reported the results of a questionnaire sent to members of the American Urological Association asking for their results in vasovasostomy. Four hundred twenty operations had been performed by 135 surgeons with a 30 to 40 percent possibility of sperm return to the semen.

In 1973, Derrick and associates² reported the results of a similar questionnaire, this time gathering 1,630 cases performed by 542 surgeons with an overall success rate of approximately 20 percent.

The very dismal results reported in the two reviews led some of us into the research laboratory to try to achieve better results with either surgical techniques or by using some sort of device, which, when inserted would cause sterility, and when removed would allow a return to fertility. Several devices were used: a pull-out suture, a minute gold valve, a magnetic ball valve, and a polypropylene, removable plug. Some of these devices were only used in experimental animals, but we reported our experience with the polypropylene plug in 1974³ which was very unpredictable. We also have worked with a silicone pull-out plug and in unpublished data in 13 patients, it was about 95 percent successful in producing sterility but very unpredictable with sperm return to the semen when removed after being in place in the vas for six months.

The development of microsurgical techniques, instruments, fibrin glue, laser assists and "welding" has led to a great improvement in the expected chance of sperm return and

also the real expectation of pregnancy and delivery of a living child.^{4,15}

We reported our results using a microsurgical technique in this journal in 1982.¹⁶ Since then, we have continued to use almost the same technique of a two layer closure. A combination of 7-0, 8-0, and 9-0, (Polyglactin 910) Vicryl[®] and Nylon suture are used (Figure 1). Also, utilization of the microsurgical tools of probe, needle guide, non-locking needle carrier, and vas approximator make performance of the procedure easier.

In a review of the most recent 24 cases, we can report a 87.5 percent rate of sperm return to the semen and a 65 percent pregnancy rate, (including two sets of twins). Adding the current cases to those previously reported, our expected rate of sperm return after vasovasostomy is 91.5 percent.

The microsurgical technique has changed very little over the past 13 years, but now we perform the procedure in an out patient surgical facility with the patient being discharged to home care, or in the case of those traveling long distances, to a motel for one or two nights prior to returning home. We recommend about 10 days of mostly rest and relaxation at home after surgery, and the wearing of a very snug scrotal support night and day for 30-45 days. A gradual return to normal activities over a 30-day period is allowed. Sexual activities may be resumed at about six to seven days post-operative, with the male taking a very passive role until about 30 days after surgery.

SUMMARY

Utilizing a microsurgical technique, specialized microsurgical instruments, and a rather

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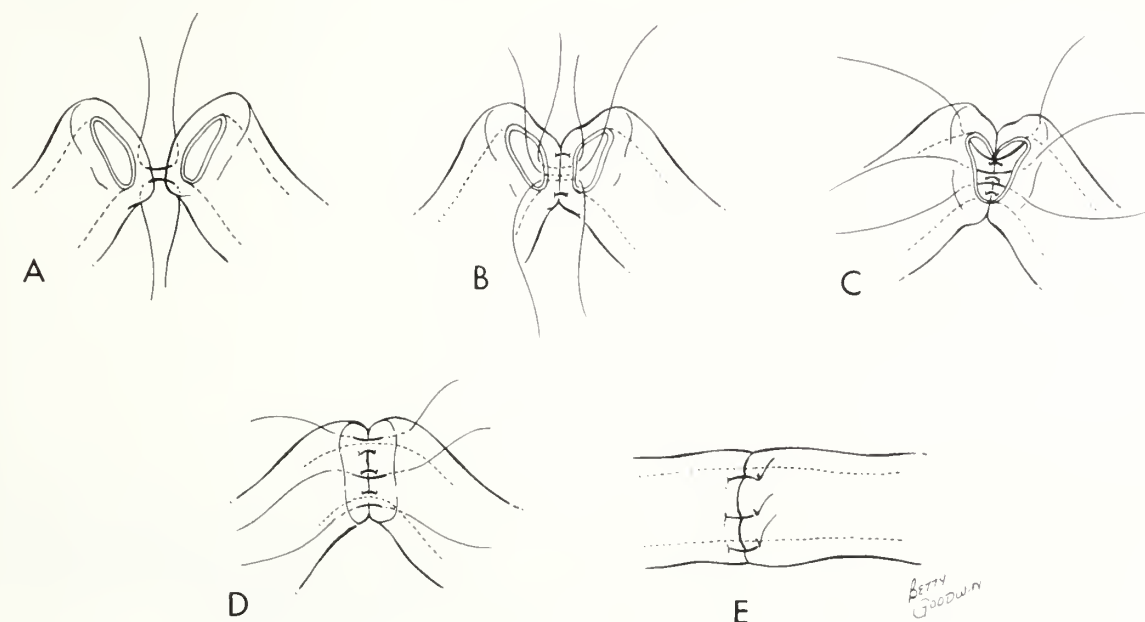


Figure 1. Technique of microsurgical vaso-vasostomy. A vas approximator is used to immobilize the two ends. Posterior muscularis sutures of 7-0 or 8-0 Polyglactin 910 (Vicryl[®]) are placed (A) first to further immobilize the vas before mucosal sutures of 8-0 or 9-0 nylon are placed (B-C-D). We usually tie the two or three posterior mucosal sutures, however, placing the anterior three or four sutures, holding them in grasping claims, tying them after all are in place. The anterior muscularis sutures can then be placed with ease, also taking advantage of the closing action of the vas approximator in the process. There is virtually no tension on the anastomosis.



Figure 2. Microsurgical instruments used in vasovasostomy.

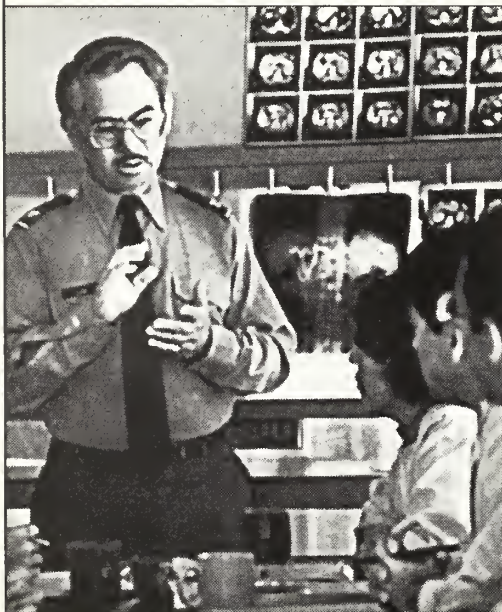
strenuous requirement of limited activities post operative, in our experience, we can predict a 90 percent chance of sperm return and 65 percent chance of pregnancy in vasectomy reversal. □

REFERENCES

1. O'Connor VJ: Anastomosis of the Vas deferens after purposeful division for sterility. *J. Urol.* 59:299, 1948.
2. Derrick FC Jr., Yarbrough W, D'Agostino J: Vaso-vasostomy: Results of a questionnaire of members of the American Urological Association. *J. Urol.* 110, 110:556, 1973.
3. Derrick F C Jr., Frensilli FJ: Experiences with a reversible vas device. *J. Urol.* 111:523, 1974.
4. Silber SJ: Perfect anatomical reconstruction of vas deferens with a new microsurgical surgical technique.

- F. S. 28:72, 1977.
5. Silber SJ: Vasectomy and vasectomy reversal. F. S. 29:125, 1978.
6. Middleton RG, Henderson D: Vas deferens anastomosis without splints and without magnification. J. Urol. 119:763, 1978.
7. Middleton RG, Urry RL: Vaso-vasostomy and semen quality. J.Urol., 123:518, 1980.
8. Willscher MK, Noviki D: Simplified technique for microscopic vaso-vasostomy. Urol. XV:147, Feb 1980.
9. Strauch B: Folding-approximating clamp to simplify micro vaso-vasostomy. Urol XVI:295, Sept. 1980.
10. Belker A: Microsurgical two-layer vaso-vasostomy: Urol. XVI:376, Oct. 1980.
11. Goldstein M: Microspike approximator for vasovasostomy: J. Urol., 134(1):74, July 1985.
12. Silverstein JI, Mellinger BC: Fibrin glue vasal anastomosis compared to conventional sutured vasovasostomy in the rat: J. Urol 145:1288-91, Jun 1991.
13. Gilbert PT, Beckert R: Laser-assisted vasovasostomy: Lasers Surg. Med. 9:42-44, 1989.
14. Gaskill DM, et al: Sutureless vasovasostomy: new technique using experimental microclip in the rat model. Urology 40:191-94, Aug. 1992.
15. Ball RA, et. al: Comparison of vasovasostomy techniques in rats utilizing conventional microsurgical suture, carbon dioxide laser, and fibrin tissue adhesives. Urology 41:479-83, May 1993.
16. Derrick F C, Rosenblum R: Vasectomy reversal: use of microsurgical technique. J. S.C. Med Assn., 78: 90-91, Feb 1982.

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SCMA NEWSLETTER

A PUBLICATION OF THE SOUTH CAROLINA MEDICAL ASSOCIATION
Joy Drennen, Editor
798-6207, in Columbia

Contributions welcomed
1-800-327-1021, outside Columbia

August 1995

HIGHLIGHTS OF JULY 19 BOARD OF TRUSTEES MEETING

The board agreed to move forward in negotiating with the SC Academy of Family Physicians, the SC Hospital Association and other interested parties toward passage of the Managed Care Improvement Act.

Also, the board voted to review SCMA bylaw provisions regarding membership in county medical societies in order to join the SCMA.

Members of the board heard a report from the Maternal,

Infant and Child Health Committee (MICH) regarding limitations of hospital stays following childbirth, and the practice of paying rebates to new mothers who voluntarily leave the hospital early following delivery.

The board also agreed to begin negotiations with a large midwestern health care company to establish a joint venture in South Carolina for the development of PPO and HMO products in the state. ☐

MEDICARE UPDATE

The August, 1995 *Medicare Advisory* has been mailed. There is a lot of information in this *Advisory*, including new instructions for filing the HCFA-1500 claim forms, and a listing of the sites of the Medicare Secondary Payer Teleconference scheduled on August 24, 1995, 1:00-3:00 pm.

Provider Satisfaction Survey to be Mailed in August:

During the month of August, you should receive a copy of the 1995 Medicare Part B Provider Satisfaction Survey. This is your chance to tell Medicare what YOU think of the job they're doing. Remember to make a mental distinction between the Medicare program itself and how it is administered. Your identity will remain anonymous. When you receive the 1995 Provider Satisfaction Survey, please take a few minutes to complete the questionnaire.

Medical Direction by Anesthesiologists: HCFA has recently clarified the policy for medical direction services furnished by anesthesiologists. HCFA's medical direction policy requires that the anesthesiologist personally participate in the induction and emergence. If an anesthesiologist is away for a short period because of an emergency, then this period cannot include induction or emergence.

Allergen Immunotherapy – Multiple Injections: CPT Code 95117 is used to report professional services for allergen immunotherapy not including provision of allergenic extracts; multiple injections. When billing for multiple injections, you should report “1” in item 24g of the HCFA-1500, regardless of the number of injections given. Do not report more than “1” in the Days of Units field.

ICD-9-CM Diagnosis Code Update: The ICD-9-CM coding system will issue an update for claims processed on and after October 1, 1995. Medicare will accept the new codes, as well as the current ICD-9-CM codes, from October 1 through December 31, 1995. You must use the new codes for professional services billed on and after January 1, 1996 or your claim may be denied. So that your Medicare claims are not denied or delayed unnecessarily, please make sure you are using the most current version of the ICD-9-CM Coding System.

Prompt Payment Interest Rate Update: Effective July 1, 1995, the new prompt payment interest rate is 6.375 percent. The new rate is effective for payment dates July 1, 1995, through December 31, 1995. Interest is payable for “clean” claims beginning on the 31st day after date of receipt. ☐

MEDICAID UPDATE

Neonatology Intensive Care Codes: Effective with dates of service on or after July 1, 1995, the CPT neonatal intensive care (NIC) codes (99295-99297) will replace the locally assigned "W" codes that are currently used to report neonatal services. There will be a grace period from July 1, 1995 to August 31, 1995, during which time providers may use either the "W" codes or CPT Neonatal Intensive Care codes. In order to use the Neonatal codes, the level of care must meet the definition of services as described in the CPT code book, and the medical records must reflect the severity of the neonate's illness and the intensity of treatment.

Mammaplasty Changes: The medical necessity criteria for Reduction Mammaplasty have been revised. Effective with date of services on or after July 1, 1995, claims must be submitted with the following support documentation:

- The removal of 400 or more grams of tissue from each breast (pathology report must be included).
- As a minimum, one-year history of the patient's symptoms related to large, pendulous breasts to reflect neck, shoulder and back pain. See the forthcoming bulletin for further details.

Each claim will be reviewed for medical necessity for the above requirements. Claims submitted without the necessary support documentation will reject.

Nurse Practitioner/Clinical Nurse Specialists: As of July 1, 1995, the program responsibilities for Nurse Practitioners and Clinical Nurse Specialists have been transferred to the Department of Physician Services. Questions concerning billing or policies issues should be directed to the program manager handling the office specialty and assigned county at (803) 253-6134. □

COMMUN-I-CARE UPDATE

Commun-I-Care (CIC), the statewide volunteer health care network and referral service, was expanded this summer to include a fourth national pharmaceutical company, clinical laboratory services, volunteer nurse practitioners, and emergency dental care.

Hoechst-Roussel has joined Pfizer, Johnson & Johnson and Searle in making its entire product line available to CIC patients. SmithKline Beecham Clinical Laboratories has signed on to do testing and lab work. The SC Dental Association will provide emergency dental care and the SC Nurses' Association has agreed to recruit its members to provide basic preventive and primary care for CIC patients.

Currently the CIC network includes 1,168 physicians, 32 hospitals, four pharmaceutical companies and more than 250 pharmacists. Former SCMA President Bart Barone, MD, serves as chairman of the statewide advisory committee which oversees this program. Commun-I-Care is designed to assist the 564,000 low-income South Carolinians without health insurance or Medicaid. □

THE SCMA MATERNAL, INFANT & CHILD HEALTH COMMITTEE ADDRESSES EARLY DISCHARGE

During the SCMA Maternal, Infant, & Child Health Committee's (MICH) July meeting, the committee discussed an issue which has received considerable media attention recently, insurance policies mandating early hospital discharge – less than 24 hours – for mothers after giving birth. Managed care organizations nationwide are only paying for 24 hours of hospital care after a routine delivery. Although the trend is just beginning in South Carolina, if Medicaid shifts towards managed care, 50 percent of the deliveries in the state could be affected by such HMO policies.

New Jersey and Maryland have passed legislation requiring insurers to pay for at least 48 hours of hospital care after a routine delivery and 96 hours after a Caesarean section. Pennsylvania has introduced similar legislation and the North Carolina Medical Society is discussing the issue with state lawmakers.

The SCMA Maternal, Infant & Child Health Committee is closely monitoring the issue of early discharge of infants and mothers in South Carolina and nationwide. The committee welcomes your comments on the issue. Please direct your comments to Elizabeth Biggers at SCMA, PO Box 11188, Columbia, SC 29211 or (803) 798-6207, ext. 236 in Columbia / 1-800-327-1021, ext. 236 statewide. □

MANAGED CARE UPDATE

HMO LICENSES IN SC

The South Carolina Department of Insurance has approved two new HMOs:

- **Aetna Health Plans of the Carolinas, Inc.** will be initially approved for York County.
- **Partners National Health Plans of North Carolina, Inc.** has been approved for York, Spartanburg, and Greenville areas.

Six more applications are in various stages of the application process, plus an additional plan that filed and then withdrew its application, but will refile soon (Coventry Corporation). Those plans include: Kaiser, PCA Health Plans, Principal Health Care, US Health Care, FHC Managed Health Services of South Carolina, Inc., and Managed Care of Florida.

HMO UPDATES

HMO Blue, one of two HMOs operated by Blue Cross Blue Shield of South Carolina (BCBS), has proposed to go virtually statewide with its 1996 offering of coverage for state employees. The plan had 314 covered lives and a system of more than 2,600 providers as of June 1995.

United Health Care has a management agreement with Physicians Health Plan of South Carolina (PHPSC). PHPSC expects the acquisition of MetraHealth by United will avail PHPSC members of more services, including PPO and indemnity product lines.

HOSPITAL NETWORK DEVELOPMENTS

Low Country Health System (LHS) is a partnership between Roper Health System and Bon-Secours-St. Francis Xavier. The joint venture is set up as a not-for-profit corporation. Roper Health System includes Roper Hospital and the former Baker Hospital, now called Roper North.

LHS has established Carolina Atlantic MSO (CAMSO), a wholly owned, for-profit subsidiary with its own operating board that manages and acquires physician practices. CAMSO is engaged in developing a physician network for managed care contracting as part of LHS and is also managing practices and helping organize a large independent primary care group, Lowcounty Medical Associates. In addition to the primary care group, CAMSO is also building a specialty network or panel called Palmetto Health Care. LHS is also developing full service primary care centers with two to six physicians.

Palmetto Community Health Network, a not-for-profit corporation founded by 13 hospitals in Northeastern South Carolina, has negotiated an agreement with BCBS. The new arrangement involves both physicians and hospitals in a discounted fee arrangement. The new product offered by BCBS will be a gatekeeper product in which a primary care physician is selected from the network panel by each covered member to coordinate his or her care.

(Excerpts reprinted with permission from *Carolina Managed Care*)

WORKSHOP CALENDAR

Effective Collection Strategies

In this ever-popular, one-day seminar presented by IC System, Inc., participants will learn how to collect professionally as a patient advocate, using techniques uniquely different from those employed by collection agencies and other third party collectors. Participants will learn how to establish a written collections policy and to maximize the effectiveness of your correspondence, as well as how to keep accounts from becoming delinquent in the first place. (Member tuition: \$150.00)

Dates & Locations: September 13, 1995 - Columbia - Sheraton Hotel & Conference Center

Capitation Strategies for Practice Survival

You may be surprised to learn that capitation already accounts for 16 percent of physician revenues, and is expected to increase to 60 percent over the next five years! In this intense, half-day workshop, you will learn the four basic steps to implementing a capitation plan that insures success. After attending, you will be able to prepare your practice for capitation, analyze a capitated contract offer, manage your practice's risk, and analyze and manage your practice's capitation plan performance. (Member tuition: \$95.00)

Dates & Locations: October 17, 1995 - Columbia - Sheraton Hotel & Conference Center
October 18, 1995 - Charleston - Omni Hotel at Charleston Place

For more information about these or other workshops or to register, please call Ginny Comer, ext. 253, at 798-6207 in Columbia or 1-800-327-1021 statewide.



"DECISIONS NEAR THE END OF LIFE"

This fall, the SCMA is joining with several state and national organizations to cosponsor the SC initiative of "Decisions Near the End of Life," an innovative program to improve terminal and palliative care in the United States. The program will be held at the Omni Hotel in Charleston on October 19-21, 1995.

"Decisions Near the End of Life" is designed to assist physicians, nurses and other clinicians in hospitals and nursing homes in making decisions about the use of life-sustaining medical technologies and other ethical issues arising in the care of dying patients and their families. Nationally, the "Decisions" program is jointly sponsored by Education Development Center, Inc. (EDC), The Hastings Center, the AMA and the Hospital Research and Educational Trust, an affiliate of the American Hospital Association. The South Carolina cosponsors include the Charleston Community Task Force on Future Care, the SC Hospital Association, SCMA, the SC Cancer Pain Initiative, Hospice for the Carolinas, and the Colleges of Medicine, Nursing, Pharmacy, Dental Medicine, Health Professions, and Graduate Studies of the Medical University of South Carolina.

For a program agenda and registration information, please contact Denise Matulis at EDC, (617) 969-7100, ext. 2398, or fax (617) 332-4318.



**SCMA 1996 ANNUAL MEETING
OMNI HOTEL, CHARLESTON, SC
APRIL 25-28, 1996**

EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY FOR DIFFICULT STAGHORN CALCULI*

WILLIAM E. POTTS, M. D.
NABIL K. BISSADA, M. D.**
WILLIAM R. TURNER, M. D.

We report three patients with large staghorn calculi, forming around ureteral stent in one patient, around stent fragments in another patient, and a symptomatic, very large calculus in the third patient which posed a dilemma for treatment because of a multitude of medical problems that rendered other alternatives unacceptable. All three patients underwent ESWL (two in multiple sessions) and all were rendered free of stones and stents.

Extracorporeal Shock Wave Lithotripsy (ESWL) has proven to be an effective method to manage most patients with urinary calculi.^{1,2} The incidence of ureteral obstruction after ESWL has been shown to be directly related to stone burden.³ In an effort to decrease the incidence of ureteral obstruction, double-pigtail stents have been placed in patients with large renal calculi before ESWL.³ However, patients with substantial stone burden are managed with percutaneous lithotripsy, a combination of percutaneous lithotripsy and ESWL, or by open stone removal.⁵⁻⁷ While there is a definite role for each of these modalities, some patients are not suitable for or absolutely refuse open or percutaneous surgery.

Herein, we report successful management of three patients with difficult staghorn calculi. The staghorn calculus formed around fragments of stent in one patient. The second

patient had a calculus forming around long-term ureteric stent. The third patient, who had a very large renal stone, was a poor operative candidate. All three patients were managed with ESWL (multiple stages in two patients).

Case 1: A 34-year-old female had a right nephrolithotomy and a partial nephrectomy with ureteral stent placement for a staghorn calculus in 1983. Multiple attempts were made to retrieve the patient for follow-up but she did not return until 1985. At that time, she had a partial staghorn calculus forming around two fragments of the stent. Cystoscopic removal of the ureteric part of the stent was accomplished. In April 1987, right nephroscopy was unsuccessful.

In July 1988, the patient was referred to the Medical University Hospital for further management. In the interim, she had converted to the Jehovah's Witness faith. Radiologic evaluation revealed partial staghorn calculus around two fragments of the stent (Fig. 1A,B). After discussion of her condition and treatment options, she refused all forms of blood transfusion. Because of the patient's refusal to accept blood transfusion if needed, it was felt that percutaneous or open stone removal may pose an increased risk. Accordingly, ESWL was elected as the initial treatment. The patient received three applications of ESWL utilizing the Dornier HM3 lithotripter on July 19, 1988; October 21, 1988; and April 18, 1989 (Fig. 1C, D). On September 11, 1989, she had passed all the stone and stent fragments (Fig. 1E).

*From the Department of Urology, Medical University of South Carolina, and the VA Medical Center, Charleston, SC.

**Address correspondence to Dr. Bissada at the Department of Urology, MUSC, 171 Ashley Avenue, Charleston, SC 29425.



Figure 1A. Patient No. 1: Plain abdominal x-ray prior to treatment.



Figure 1B. Patient No. 1: IVP prior to treatment.



Figure 1C. Patient No. 1: Plain abdominal x-ray after 1 ESWL.



Figure 1D. Patient No. 1: Plain abdominal x-ray after 2 ESWL.

Case 2: A 23-year-old myelodysplastic male had an indwelling right double-pigtail ureteric stent for management of ureterovesical stricture. On referral, the patient had a staghorn calculus around the renal part of the ureteric stent and another calculus around the bladder end of the stent (Fig. 2A). The patient was managed initially with ESWL to the renal and vesical calculi. The renal calculus

was fragmented and eliminated. The bladder calculus remained intact and was managed with cystoscopic electrohydraulic lithotripsy (Fig. 2B). After elimination of the calculi, urodynamic evaluation demonstrated poorly compliant bladder and the patient was managed with augmentation ileocystoplasty with ureterointestinal reimplantation.



Figure 1E. Patient No. 1: Plain abdominal x-ray at end of therapy.



Figure 2A. Patient No. 2: Plain abdominal x-ray prior to therapy.

Case 3: A 68-year-old female presented with sepsis and renal insufficiency. Investigations revealed a serum creatinine of 8.6, a non-functioning left kidney, and a poorly functioning right kidney with a 7 cm x 6 cm staghorn calculus (Figure 3A). The patient had multiple serious medical problems and was a Jehovah's Witness. Due to the patient's medical condition and her refusal to accept blood transfusion if needed, it was decided to attempt staged ESWL as initial management. She required six stages of ESWL to render her stone-free (Fig. 3B-D).

DISCUSSION

Stone formation around ureteral stents is a known complication of longterm stenting. Multiple therapeutic modalities may be used to deal with this problem. Anatomic nephrolithotomy, percutaneous extraction, and percutaneous dissolution have been described. Our two cases demonstrate that ESWL may be successful in some patients with stones forming around ureteral stents. In the first patient, stent fragments passed spon-



Figure 2B. Patient No. 2: Plain abdominal film after ESWL to renal stone and electrohydraulic lithotripsy to bladder stone.



Figure 3A. Patient No. 3: Plain abdominal x-ray prior to treatment.



Figure 3B. Patient No. 3: Plain abdominal x-ray after 2 ESWL.



Figure 3C. Patient No. 3: Plain abdominal x-ray after 3 ESWL.



Figure 3D. Patient No. 3: Plain abdominal x-ray after 4 ESWL.



Figure 3E. Patient No. 3: Plain abdominal x-ray after 6 ESWL.

taneously after the stone was fragmented and eliminated. Even if the stent fragments had not passed spontaneously, their removal with a ureteronephroscope would have been an option. ESWL was successful in the second patient in elimination of the renal stone allowing safe extraction of the ureteric stent. The third patient was not a candidate for standard operative or expectant therapy. The staghorn calculous in a solitary-functioning right kidney was causing serious life threaten-

ing sepsis. Although she required numerous ESWL sessions and had considerable delay and recurrent moderate morbidity, she was finally rendered stone-free, without the availability of ESWL, the choices were expectant, endoscopic or open surgical management, all with very high morbidity. □

REFERENCES

1. Chaussy C, Schmiedt EJ, Brendel W, Forssmann B, Walther V. First clinical experience with extracorporeally induced destruction of kidney stones by shock waves. *J Urol* 127:417, 1982.
2. Neto NR Jr., Lemos CG, Claro JF. In situ extracorporeal shock wave lithotripsy for ureteral calculi. *J Urol* 144:253, 1990.
3. Bierkens AF, Hendris AJM, Lemmen WAJG, Debruyne FMJ. Extracorporeal shock wave lithotripsy for large renal calculi: the role of ureteral stents. A randomized trial. *J. Urol* 145:699, 1991.
4. Pryor JL, Jenkins AD. Use of double-pigtail stents in extracorporeal shock wave lithotripsy. *J Urol* 143:475, 1990.
5. S. Segura JW, Petterson DE, LeRoy AJ, Williams HJ Jr., Barrett DM, Benson RC, ay GR Jr., Bender CE. Percutaneous removal of kidney stones: Review of 1,000 Cases. *J Urol* 134:1077, 1985.
6. Segura JW, Petterson DE, LeRoy AJ. Combined percutaneous ultrasonic lithotripsy and extracorporeal shock wave lithotripsy for struvite staghorn calculi. *World J Urol* 5:245, 1987.
7. Assimios DG, Wrenn JJ, Harrison LH, McCullough DL, Boyce WH, Taylor CL, Zagoria RJ, Dyer AB. A comparison of anatomic nephrolithotomy and percutaneous nephrolithotomy with and without extracorporeal shock wave lithotripsy for management of patients with staghorn calculi. *J. Urol* 145:710, 1991.
8. Schulze KA, Wettlaufer JN, and Oldani G. Encrustation and stone formation: Complication of indwelling ureteral stents. *Urology*, 25:616, 1989.

THE GOOD GIFT: A COMPARISON OF THE ELI LILLY PRESENTATION COPIES OF *AEQUANIMITAS**

ROBERT C. KIMBROUGH, III, M. D.**

The book *Aequanimitas With other Addresses to Medical Students, Nurses and Practitioners of Medicine* by Sir William Osler was first published in the United Kingdom in 1904 by H. K. Lewis. It was simultaneously published in the United States by P. Blakiston and Sons. Numerous editions and printings have followed. The second edition had the addition of three addresses and "remarks" from a farewell dinner. In the United States the third edition was issued in February of 1932 and contained the same material as the second edition. Eli Lilly and Company purchased a large number of the third United States edition and distributed these to graduating medical students throughout the United States from 1932 through 1953. Most bibliophiles have considered these volumes to be identical. However, there are numerous differences.

From 1932 through 1953 the Eli Lilly Company distributed approximately 150,000 copies of the third edition of *Aequanimitas* to graduating medical students in the United States. English was the usual language. However, there is a Spanish edition published in 1942 and a Portuguese edition published in 1944. There are at least seven different United States printings. The largest of these was of February 1932. Other printings are dated: November 1942, October 1943, August 1944, January 1947, December 1948 and February 1951. The publisher of the first, second, and third United States editions of *Aequanimitas* was the Blakiston Company of Philadelphia.

They published all of the Eli Lilly presentation copies. Blakiston was absorbed by McGraw-Hill in 1954. The Maple Press of York, Pennsylvania was the printer of all these volumes. Information from catalogs of the Blakiston Company dated in 1954 indicates the last of these similar volumes was printed in 1951. The catalog from McGraw-Hill dated 1969 list a reprint of the book in 1961. However, this issue is quite different from those that were used as presentation copies.

Each of the presentation books was accompanied by a letter pasted on the free front end paper. In addition, some of the books were presented with business cards of the pharmaceutical company. Over the years the contents of the letters have changed, the letterheads have changed, and the signatures of the President of Eli Lilly and Company have also changed.

The Eli Lilly and Company was founded by Colonel Eli Lilly in the late 1800s. It is headquartered in Indianapolis, Indiana. Colonel Lilly remained president from 1876 to 1898. His son, J. K. Lilly, Sr., became president in 1898. He remained in that position until 1932. He then retired and died in 1948. J. K. Lilly, Sr. had two sons, Eli Lilly and J. K. Lilly, Jr. Eli Lilly became president of the company in 1932 and continued until 1947. J. K. Lilly, Jr. became president in 1947 and remained president until 1953. Of note, while J. K. Lilly, Sr. was living J. K. Lilly, Jr. retained the Jr. in correspondence and signature. When J. K. Lilly, Sr. died in 1948 J. K. Lilly, Jr. dropped the Jr.

The data to be presented have been gleaned from the author's personal book collection, and information kindly supplied by historians, bibliophiles, book dealers, and librarians. Information from annotated bibliographies,

*Presented in part at the 24th Annual Meeting of The American Osler Society, London, May 24, 1995.

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computer, and hand searches of various catalogs has also been included.^{1,5}

DESCRIPTION

The basic content of the presentation volumes is identical. Each has 453 pages. Despite changes in size and paper material, the arrangement of the wording is the same on each page of the various printings. All volumes are cloth bound with a dark green cloth, Octavo. The differences are to be found in the congratulatory letters, the title page layout and wording, the reverse of the title page layout and wording, the spine, and the size and paper used in publication.

February 1932: The size of the boards measures 8 1/4" high, 5 3/4" deep and 1 1/2" wide. The leafs measure 8" high, 5 1/4" deep and 1 1/4" wide. The spine has gold imprinting with two straight lines at the top and two at the bottom (Figure 1). The title is worded: *Aequanimitas with other addresses*. The author is listed as - Osler. In the mid of the spine are the words third edition. At the bottom of the spine is the word Blakiston. The title page reads: *Aequanimitas: With other Addresses to Medical Students, Nurses, and Practitioners of Medicine*. The author is listed "by Sir William Osler, Bt., M.D., F.R.S., late Regius Professor of Medicine, Oxford, Honorary Professor of Medicine, Johns Hopkins University. In the center of the title page are the words third edition (Figure 2).

The publishers name and city are at the bottom of the title page in the arrangement of:

Philadelphia

P. Blakiston's Son & Company, INC.

1932

The verso of the title page is blank except at the bottom. The printing company is noted thusly:

PRINTED IN U.S.A.

BY THE MAPLE PRESS COMPANY, YORK, PA.

The congratulations letter has four paragraphs. The letterhead reads:

ELI LILLY AND COMPANY,

INDIANAPOLIS, U.S.A.

The words Office of Eli Lilly, President appear on the left and are in block letters. The



Figure 1. 1932 and 1947 editions.

AEQUANIMITAS

With other Addresses to Medical
Students, Nurses and Prac-
titioners of Medicine

By

Sir WILLIAM OSLER, Bt., M.D., F.R.S.

Late Regius Professor of Medicine, Oxford

Honorary Professor of Medicine, Johns Hopkins University

THIRD EDITION

PHILADELPHIA

P. BLAKISTON'S SON & CO., Inc.

1932

Figure 2. Title page, 1932.

date is May, 1932, with 1932 being in arabic numerals. In the lower left corner of the letter are two capitalized letters "EL". The only hyphenated word in the entire letter is in the first sentence of the last paragraph. There, the word "inspiration" is hyphenated between "i" and "r." The closing "sincerely yours" is centered beneath the word "life" in the last sentence of the last paragraph. Beneath the signature of Eli Lilly is the word "President" that is placed directly beneath the "y" in the word "Lilly".

1933: Is the same as 1932 except the layout of the letter. The letterhead is in three lines:

ELI LILLY AND COMPANY
INDIANAPOLIS, INDIANA
U.S.A.

The date is spelled out and there is no month indication. The letter contains four paragraphs, but with a different arrangement than the first letter. The word "attainment" is hyphenated in the first sentence of the first paragraph, the word "profession" is hyphenated in the last sentence of the second paragraph, the words "knowledge" and "persistence" are hyphenated in the third paragraph and the word "inspiration" is no longer hyphenated in the last paragraph. The closing "sincerely yours" is now shifted to the left to the middle of the page. "EL" no longer appears in the lower left corner.

1934: Is the same as 1933, except for the layout of the congratulation letter. The only hyphenated word in the letter is "passionate" in the second line of the third paragraph. The closing now is placed somewhat to the right under the word "abundant" in the last line of the last paragraph. The word "President" is shifted to the left under "Ely".

1935: The book is the same as 1932 and the letterhead has reverted to that of 1932 also. The layout of the four paragraphs is again different with numerous hyphenated words (Figure 3).

1936: Is the same as 1935.

1936-1942: The congratulation letters cease to have any date. The layout of the letters continues to differ in the closing, with placement varying from right to left.

ELI LILLY AND COMPANY
INDIANAPOLIS, U.S.A.

OFFICE OF
ELI LILLY AND COMPANY

Nineteen Thirty-Five

Dear Doctor:

Together with congratulations on your attainment of a medical degree, this volume of addresses by Sir William Osler, who adorned your profession in the United States for so many years, is cordially presented.

As the addresses by this master mind of modern medicine are read, may you catch his vision of the almost boundless possibilities of your chosen profession.

May you share with him his "relish of knowledge" and his absorbing love and passionate, persistent search for truth.

Above all, may there come to you an inspiration which will enable you to live a rich, a happy, and an abundant life.

Sincerely yours,

ELI LILLY AND COMPANY

Eli Lilly
President

Figure 3. Letter, 1935.

At some time the title page changes. However, there is nothing to indicate the date of that change (Figure 4). The change in the title page is with the indication of the publisher which now reads: The Blakiston Company centered, and beneath that, centered, *Philadelphia*. The letter accompanying these volumes has no date.

One of the undated letters accompanying the "new" title page has the wording changed. The word "writings" is substituted for the word "addresses" in the first sentence of the second paragraph. The overall layout of this letter is also different, as is the ending of the letter. The words "sincerely yours" are now under "an" in the last sentence. The word "president" is now shifted entirely to the right under the word "company" in Eli Lilly and Company.

November 1942: The book and the title page are the same as those later than 1936. However, the letter is now changed to a two paragraph letter, again without a date.

October 1943: The book size and the title

AEQUANIMITAS

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titioners of Medicine

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Sir WILLIAM OSLER, Bt., M.D., F.R.S.
Late Regius Professor of Medicine, Oxford
Honorary Professor of Medicine, Johns Hopkins University

THIRD EDITION

THE BLAKISTON COMPANY
Philadelphia

Figure 4. Title page, 1936-1942.

page are the same as those after 1936. However, there are now two styles of letters. The letterhead changes to include the postal zone reading: Indianapolis 6, U.S.A. and the words "Office of" and "President" are now italicized rather than in block. The letter's layout and content are the same.

August 1944: Is the same as October 1943.

January 1947: The book size changes (Figure 1). The boards now measure 8 3/16" high, 5 1/2" deep, and 1 1/4" wide. The paper is thinner. The leafs measure 7 7/8" high, 5 3/16" deep, and 1" to 1 1/4" wide. A logo has appeared on the spine above the word "Blakiston". This is a script "B" with an open book beneath. On the title page a similar logo appears above "The Blakiston Company" (Figure 5). On the reverse of the title page, in addition to indicating the printing date, "United States of America" is fully spelled out rather than abbreviated.

The letterhead has now changed to J. K. Lilly, Jr. as has the signature. The two paragraph letter composition and layout is the

same as October 1943. The closing has been moved to the left (Figure 6).

December 1948: The size of the book returns to the original 1932 size and the paper is the same as the 1932 paper. Information on the spine and the title page remain the same as the 1947 book. The reverse of the title page now reads "printing of December 1948". The printers name and location are the same as that of January 1947. The only change in the letter consist of deleting the abbreviation for Jr., both in the letterhead and the signature. The words "sincerely yours" are the furthest to the right of any of the two paragraph/letters.

February 1951: The same as 1948, except on the reverse of the title page the word "reprinted" has been substituted for the word "printing" so that it now reads "reprinted, February 1951". The words "sincerely yours" and the signature have been moved to the left, again similar to that of 1943.

AEQUANIMITAS

With other Addresses to Medical
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titioners of Medicine

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Sir WILLIAM OSLER, Bt., M.D., F.R.S.
Late Regius Professor of Medicine, Oxford
Honorary Professor of Medicine, Johns Hopkins University

THIRD EDITION



THE BLAKISTON COMPANY
Philadelphia

Figure 5. Title page, 1947.

ELI LILLY AND COMPANY

INDIANAPOLIS 6, U.S.A.

Office of
J. K. LILLY, JR., President

Dear Doctor:

Please accept our sincere congratulations on your attainment of a medical degree.

To commemorate the occasion we are presenting to you the accompanying volume of addresses by Sir William Osler, who followed your profession for so many years. We hope that as you read this book you will appreciate and share Sir William's inspiration, his breadth of vision, and, above all, his persistent search for truth.

Sincerely yours,

ELI LILLY AND COMPANY

President

Figure 6. Letter, 1947.

DISCUSSION

The above descriptions indicate many differences in the makeup of the book and the presentation letters. The two paragraph letters content and layout are similar enough to believe that they were machine produced. However, I believe the letters from 1932 to 1942 were individually typed. The use of typing pools was quite common in large companies of that era. The most unique of the volumes is that of January 1947. It differs in size, the addition of - B - Logo, the change in wording of the printer's location on the reverse title page, change in the letterhead of the two paragraph letter, and the use of the abbreviation for Jr. in J. K. Lilly's name on the letterhead and the signature. The next year the Jr. no longer appears.

Thus, the Eli Lilly presentation copies of the third edition of *Aequanimitas* are not identical, except for the contents of the

addresses. The recognition of these differences should open new fields for research and collecting. It is unfortunate that this good gift is no longer distributed to physicians.

SUMMARY

The Eli Lilly Pharmaceutical Company of Indianapolis, Indiana distributed some 150,000 copies of the third edition of Sir William Osler's *Aequanimitas* to graduating medical students between 1932 and 1953. Bibliophiles have considered these volumes identical. However, there were at least seven different printings in English and one in Spanish and one in Portuguese. The size of the book and type of paper changed over the years. The title page, spine information, and printing information also changed. A congratulatory letter from Eli Lilly and Company was placed in the front of each book. These letters have many differences. Thus, the volumes are not identical and the recognition of these differences opens a new field for research and collecting. □

ACKNOWLEDGEMENT

I wish to thank Drs. Larry Longo, Richard Golden, Bruce Fye, Robert Hudson, Robert Joy and Joseph Wheat, and Professor Jack Key for their invaluable assistance. I also thank Ms. Anita Martin and Ms. Lisa Baines, the Archivist of the Eli Lilly and Company, Ms. Jeannie Cooper of McGraw-Hill Inc. supplied copies of the old catalogs.

REFERENCES

1. Golden, Richard L and Roland, Charles G. Sir William Osler: An annotated bibliography with illustrations. Norman Publishing, San Francisco, 1988.
2. Norman, Jeremy M, Editor. Mortons Medical Bibliography. An annotated check-list of texts illustrating the history of medicine. 5th Edition. Scolar Press, United Kingdom, 1991.
3. The Library of Congress Computerized Catalog. Containing materials of 1898 to 1979.
4. The Catalog of the British Museum. Published by the Trustees of the British Museum. London, England.
5. New York Academy of Medicine Catalog. Published by Hall and Company, Boston, Massachusetts.

Editorials

AEQUANIMITAS REVISITED

In this issue of *The Journal*, Dr. Robert Kimbrough presents a scholarly analysis of the various printings of the third edition of *Aequanimitas*, Sir William Osler's celebrated collection of essays. Between 1932 and 1953, The Eli Lilly Pharmaceutical Company distributed nearly 150,000 copies of this remarkable volume to graduating medical students. One of the copies was given to my father, who gave it to me. I suspect that I am but one of thousands of second- and even third-generation beneficiaries who treasure these volumes and continue to be inspired by Osler's eloquent expressions of medicine's highest ideals.

Osler's felicitous writing style has evoked much comment over the years. A master of the pithy phrase, he is often best remembered for his widely-quoted epigrams. His essays still make good reading, and most of them exude the author's easy familiarity not only with medicine but also with history, literature, and Latin. One gains the impression that Osler must have been a naturally-gifted writer and public speaker. Such was not the case. Early in his career, his delivery was commonly described as "halting" and his writing was far from brilliant. Osler succeeded as a great communicator because he worked hard at it.

Osler's skill as a writer, like his skill as a clinician, hinged on what he called the "master-word:"

Though a little one, the master-word looms large in meaning. It is the open sesame to every portal, the great equalizer in the world, the true philosopher's stone, which transmutes all the base metal of humanity into gold. The stupid man among you it will make bright, the bright man brilliant, and the brilliant student steady. With the magic

word in your heart all things are possible, and without it all study is vanity and vexation... And the master-word is *Work*, a little one, as I have said, but fraught with momentous sequences if you can but write it on the tablets of your hearts...¹

Most of the essays that comprise the *Aequanimitas* collection were given as invited lectures or commencement addresses. Osler could easily have met these obligations with boilerplate speeches that would have required little preparation. He chose instead to honor these audiences with refreshingly original remarks, and although he made it look easy, any writer can understand that it was not.² Even to the end of his career, his essays were extensively revised prior to delivery.

Osler was a master of positive thinking who taught that the best way to retain one's focus and idealism is to commune regularly with the great writers of the past. To this end, he proposed a "Bed-Side Library for Medical Students" that can be found on the last page of the *Aequanimitas* volume. The student, he suggested, should devote the last half hour of the day to what he called "the inner education." His recommended reading list consisted of The Bible, Shakespeare, Montaigne, Plutarch's *Lives*, Marcus Aurelius, Epictetus, Sir Thomas Browne's *Religio Medici*, Cervantes' *Don Quixote*, Emerson, and Oliver Wendell Holmes' Breakfast-Table Series. Today's bedtime tastes are more inclined to the likes of Jay Leno or David Letterman, and with a few exceptions (notably, The Bible, Shakespeare, and *Don Quixote*), few of Osler's authors are read closely by today's students. And that's a shame, for seldom has our profession needed idealism and inner strength more than it does today.

TABLE 1
SOME THEMES ADDRESSED IN THE *AEQUANIMITAS* ESSAYS

" <i>Aequanimitas</i> "	— imperturbability and mental calmness as practical virtues for physicians
" <i>Doctor and Nurse</i> "	— the value of "a busy, useful, and happy" life of service to others
" <i>Teacher and Student</i> "	— the importance of idealism and diligence in the academic setting
" <i>Physic and Physicians as Depicted in Plato</i> "	— the role of physicians in ancient Greece
" <i>The Leaven of Science</i> "	— the scientific spirit, properly understood, elevates all of society
" <i>The Army Surgeon</i> "	— we should always make the most of our circumstances
" <i>Teaching and Thinking</i> "	— medical schools need both teachers and researchers
" <i>Internal Medicine as a Vocation</i> "	— the challenges and rewards of becoming a consultant
" <i>Nurse and Patient</i> "	— nurses must balance sympathy with taciturnity
" <i>British Medicine in Great Britain</i> "	— Linacre, Harvey, Sydenham, and others
" <i>After Twenty-Five Years</i> "	— reflections on the student life from the professor's perspective
" <i>Books and Men</i> "	— the importance of books to libraries and to medical practitioners
" <i>Medicine in the Nineteenth Century</i> "	— growth of scientific medicine and public health
" <i>Chauvinism in Medicine</i> "	— medicine as an open, worldwide profession
" <i>Some Aspects of American Medical Bibliography</i> "	— America's contributions to medicine
" <i>The Hospital as a College</i> "	— clinically-oriented education at The Johns Hopkins Hospital
" <i>On the Educational Value of the Medical Society</i> "	— the need for continuing education
" <i>The Master-Word in Medicine</i> "	— focused hard work is the very "measure of success"
" <i>The Fixed Period</i> "	— one is unlikely to make original contributions after age sixty
" <i>The Student Life</i> "	— the need to approach medicine from a broad-minded perspective
" <i>Unity, Peace and Concord</i> "	— medicine "forms a remarkable world-wide unit"
" <i>L'Envoi</i> "	— success is best predicated on worthy goals and lofty ideals

Most of the themes developed in *Aequanimitas* reflect near-universal values and therefore can be passed without comment (Table 1). Some, such as the importance of continuing education and the need to eschew chauvinism in all of its forms, strike us as remarkably prescient. However, two of the essays are sometimes attacked on the grounds that Osler was out of touch with reality. His remarks in the title essay, "*Aequanimitas*," are sometimes taken as the antithesis of compassion. His remarks in "*The Fixed Period*" are sometimes taken as opposition to the potential usefulness of older citizens. In both cases, the critics are misled.

"*Aequanimitas*" was given in 1889 as the valedictory address to graduating medical students at The University of Pennsylvania as Osler prepared to leave Philadelphia for Baltimore. It was one of Osler's shorter addresses. He focused on two desirable attributes: imperturbability and its mental equivalent, equanimity (*aequanimitas*). He held that imperturbability was "largely a bodily endowment." He recognized that laypersons often mistook the appearance of cool detachment for callousness. However, it

was a "positive necessity in the exercise of a calm judgment, in carrying out delicate observations." *Aequanimitas*, on the other hand, was a state of mental calmness that was especially useful for helping physicians "bear with composure the misfortunes of our neighbors." So strongly did Osler feel about this point that when he was knighted in 1911, he took *Aequanimitas* as the motto for his coat of arms.

One critic, in an essay entitled "Against *Aequanimitas*," went so far as to claim that "the major voice that seems to emerge from all the serious, uplifting advice is the public tone of the academic snob." *Aequanimitas* was seen as cool detachment that discourages compassion, a much higher virtue for physicians.³ This accusation does Osler gross injustice. He made it clear in the second paragraph of the address his intent to discuss but two of many desirable attributes:

I could have the heart to spare you, poor, careworn survivors of a hard struggle, so "lean and pale and leaden-eyed with study;" and my tender mercy constrains me to consider but two of the score of elements which may make or mar your lives—which

may contribute to your success, or help you in the days of failure.

And he also made it clear that equanimity and compassion are hardly incompatible:

Cultivate, then, gentlemen such a judicious measure of obtuseness as will enable you to meet the exigencies of practice with firmness and courage, without, at the same time, hardening "the human heart by which we live."⁴

This was a recurrent theme of Osler's work; for example, in another address, he said:

As the practice of medicine is not a business and can never be one, the education of the heart—the moral side of man—must keep pace with the education of the head. Our fellow creatures cannot be dealt with as man deals in corn and coal; "the human heart by which we live" must control our professional relations.⁵

To criticize Osler for emphasizing *aequanimitas* is to set up a straw man of the worst sort.

"The Fixed Period" was given in 1905 as Osler's farewell address to the faculty of The Johns Hopkins University as he prepared to leave Baltimore for Oxford. Keenly aware of his popularity, he tried to console his audience by reflecting that, at 55, he was past his prime. He therefore put forth "two fixed ideas well known to my friends, harmless obsessions with which I sometimes bore them, but which have a direct bearing on this important problem." He continued:

The first is the comparative uselessness of men above forty years of age. This may seem shocking, and yet read aright the world's history bears out the statement. Take the sum of human achievement in action, in science, in art, in literature—subtract the work of the men above forty, and while we should miss great treasures, even priceless treasures, we would practically be where we are to-day.

It was the next point that got him into trouble:

My second fixed idea is the uselessness of men above sixty years of age, and the incalculable benefit it would be in commercial, political and in professional

life if, as a matter of course, men stopped work at this age.... In that charming novel, *The Fixed Period*, Anthony Trollope discusses the practical advantages in modern life of a return to this ancient usage, and the plot hinges upon the admirable scheme of a college into which at sixty men retired for a year of contemplation before a peaceful departure by chloroform.⁶

On this occasion, Osler's penchant for humor and literary allusion proved to be most unfortunate. Newspapers throughout the country blared: "OSLER RECOMMENDS CHLOROFORM AT SIXTY." Osler's name became a household word, and "to Oslerize" became synonymous with euthanasia. To this day, Osler's remarks are sometimes misconstrued as hostility toward older citizens.

Four points should be made in Osler's defense. First, Osler loved old people. At Oxford, he would make a special point of befriending the elderly pensioners at Ewelme, an almshouse that had received little attention from the previous Regius Professors of Medicine.⁷ Second, his allusion to Trollope's novel was not only in jest but was also incorrect; Trollope never mentioned chloroform as the method for euthanasia. Third, his remarks were probably based on deep philosophical and religious conviction that stemmed from his close reading of Sir Thomas Browne's *Religio Medici*.⁸ Finally, Osler became his own best example that the later years of life can be among the finest and most productive (Table 2). The entire second volume of Harvey Cushing's biography consists of the last 14 years of his life, the years of alleged "uselessness."⁹ And one might add that Osler also became a good example of his admonition to young physicians: "Beware of words—they are dangerous things. They change color like the chameleon, and they return with a boomerang."¹⁰

William Osler took many stands: for better medical education, for better medical science, for better public health, for better appreciation of the humanities, and for good

TABLE 2
OSLER'S LIFE UNDERSTOOD AS HIS RESPONSE TO DEVELOPMENTAL TASKS

STAGE (approximate ages)*	DEVELOPMENTAL TASKS	WILLIAM OSLER
Identity (21 to 25)	Acquire skills; develop a track record	Decides to become a physician
Generativity (35 to 55)	Consolidate reputation; make one's mark	Becomes a famous clinician-teacher
Consolidation (post 55)	Come to terms with how life has been used; reflect	Takes position at Oxford becomes elder statesman

*After Erikson E, *Childhood and Society* (New York: Norton, 1950).

will throughout the medical profession—to name a few. Although his writing style, like his style of medical practice, sometimes seems a bit old-fashioned, his idealism does not. More than a century later, in our present climate of much uncertainty, we would do well to remember Osler's parting blessing to those graduating students at The University of Pennsylvania: "Gentlemen,—Farewell, and take with you into the struggle the watchword of the good old Roman—*Aequanimitas*."

—CSB

REFERENCES

1. Osler, W: "The Master-Word in Medicine," in *Aequanimitas* (Philadelphia: P. Plakiston's Son & Co., 356-357, 1932).
2. White W: *Aequanimitas: Osler's Inspirational*

Essays. Bull Hist Med 6: 820-833, 1938.

3. Weissman G: Against *Aequanimitas*. Hospital Practice: 159-169, June, 1984.
4. Osler W: "Aequanimitas," in *Aequanimitas*, 3-11.
5. Osler W: "On the Educational Value of the Medical Society," in *Aequanimitas*, 333.
6. Osler W, "The Fixed Period," in *Aequanimitas*, 376-383.
7. Nation EF: Sir William Osler, the Master of Ewelme. Canadian Medical Association Journal 109: 1128-1132, 1973.
8. Berk SL: Sir William Osler, Ageism, and "The Fixed Period:" A Secret Revealed. In Barondess JA, Roland CG, eds.: *The Persisting Osler-II* (Malabar, Florida: Krieger Publishing Company, 297-301, 1994.)
9. Cushing H: *The Life of Sir William Osler* (Oxford: The Clarendon Press, 1925).
10. Thayer, WS: "Osler the Teacher," in *Sir William Osler, Bart.: Brief Tributes to His Personality, Influence, and Public Service* (Baltimore: The Johns Hopkins Press, 52, 1920).

On the Cover:

FREDERICK HOLLICK, M. D.

The celebrated Dr. Hollick has published a work in Philadelphia, entitled *Outlines of Anatomy and Physiology for Popular Use*, which brings the study of those important sciences home to every reader. It is accompanied by an ingeniously arranged plate, which opens by pieces, exhibiting the anatomy of the human structure, with explanations in English, and is thus divested of all technicalities and mysteries by which the ordinary study is shrouded. Dr. Hollick seems determined to do his part in a medical way towards affording that knowledge to the people embraced in the axiom, "Know thyself."

"The ingeniously arranged plate" is the subject of our cover this month. The Waring Library's copy of Hollick's book was published in 1847, and on Christmas 1866 was given and inscribed to T. Grange Simons by his brother-in-law, Thomas M. Waring. Simons would graduate from the Medical College in March of 1867 and become a much loved doctor in Charleston.

Meanwhile, Dr. Hollick was giving a series of lectures on "The Origin of Life" using a "manikin or Artificial Anatomy" which "represents the human body with admirable perfection....can be taken apart, opened, examined with an ease that renders the study as perfect as an actual dissection, without the desagremens that attend a scrutiny of the real subject."

Whether on economic or moral grounds, these lectures were not universally welcomed. In fact, Dr. Hollick "ran against some interested jackanapes, who had the Doctor presented by the Grand Jury of Philadelphia." The effort was made "to cast contempt and odium, not only upon the able and eloquent lecturer, but upon the numerous class of females attendant upon the same." This nefarious scheme was foiled: the doctor was acquitted, the ladies' reputation restored, and all lived, presumably, happily ever after.

Betty Newsom
The Waring Historical Library

PHYSICIAN RECOGNITION AWARDS

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Alliance Page

THE 1995 AMA ALLIANCE, INC. ANNUAL SESSION

This meeting, always exciting and informative, took place on June 18-20 at the Drake in Chicago. A little fitness, a little laughter and a lot of issues affecting the entire medical community were the topics.

Joining me for this session were Kiki Sanford, Brenda Cate, Dee Jewell, Lisa Schroeder, and Gail Robinson. Attending also from South Carolina were Hope Grayson and Betty Hester.

At the House of Delegates opening session, Dr. Robert E. McAfee, AMA President, gave the keynote address. He discussed briefly the changes in health care delivery and the rising number of HMOs. His main emphasis, however, was on our country's number one public health problem—domestic violence. The AMA Alliance is joining the AMA in addressing this issue by adopting a national unified health project entitled "SAVE: Stop America's Violence Everywhere."

"The Capital Step," a comedy troupe of current and former Congressional staffers, entertained the delegates with their bipartisan brand of humor in the form of new lyrics for familiar tunes—such as a shot at health care reform in "You Can Suture Yourself at Home" (sung to the tune of "Consider Yourself"). Jane Brody, national personal health columnist for *The New York Times* brought us her message on wholesome food and fitness, with an emphasis on moderation and variety.

The "Focus '95-'96" goal for AMA-ERF is to make sure that one thing does not change: Support for the physicians of tomorrow from the physicians of today. Of the 2.2 million total dollars raised this year, 75 percent was raised by the alliance. Goals for Health Promotion, Legislation and Membership will appear in upcoming issues of this journal.

Of great concern and consideration by the delegates was a strategic plan of 19 recommendations presented by the Board of Directors to move the organization efficiently into the 21st century. The key to all of the recommendations was membership retention and growth; and named important to both of these was (1) a universal identity in name for all levels of the organization and (2) a unifying health issue for the entire organization. Changing to a unified name did not pass; however, a unified health issue did (SAVE).

Betty Hester gave the SCMA Alliance report and we were excited that her county, Florence, won a beautiful crystal bowl in a drawing for "County Recognition: Play Ball." To participate, counties had to score runs by touching each of four specified bases in increasing their membership.

We are delighted that Hope Grayson will be serving on the 1995-96 Alliance Board of Directors as Bylaws Chair.

At the closing of this session, Sharon Scott of Roseburg, Oregon, was installed as the 1995-96 AMA Alliance President.

Janelle L. Otherson (Mrs. H. Biemann, Jr.)
President-Elect and Chairman of Delegates



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Presentations dealing with any aspect of physician health, including issues of well-being, impairment, disability, treatment, and education are welcome. Of particular interest are:

- Coping with changing economic or practice circumstances
- Stress and physician health
- Epidemiologic data
- The effects of violence directed at physicians
- Violence occurring within physicians' families
- Patient exploitation
- Mental illness, including substance abuse
- Physical illness and disability
- Special populations
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- Physician well-being and family functioning
- Updates on clinical areas (depression, pharmacotherapy, etc.)

Three types of presentations are welcome:

- Poster presentations: written presentations of data-based research
- Paper sessions: Oral presentations of scientific, data-based findings on issues of physician health. Paper presentations will be grouped into related panels, with individual papers presented in 20 minute time slots
- Workshops: Training or instructional presentations designed to improve the skills and knowledge of persons working in the physician health field

Abstracts for all presentations must be submitted on the abstract submission form which is available from: American Medical Association, Physician Health Program, Attn. E. Tejcek, 515 North State Street, Chicago, IL 60610.

All presenters must register for the conference and will pay the AMA member rate. Presenters will be responsible for their own expenses.

Questions or requests for abstract submission forms may be sent to the address above or directed to 312 464-5066 or faxed to 312 464-5841.

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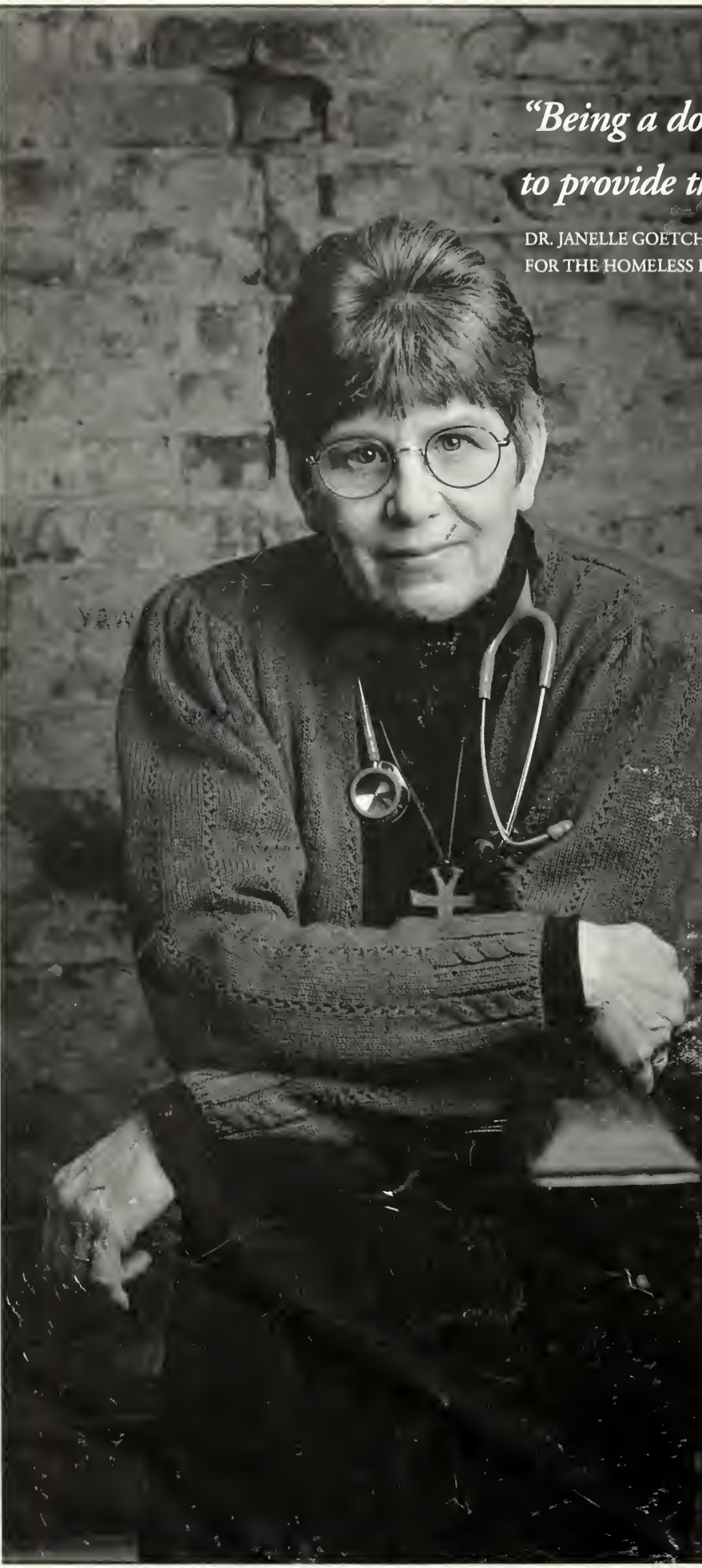
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The Journal

OF THE SOUTH CAROLINA MEDICAL ASSOCIATION



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**INFECTION AND DISEASE DUE TO HUMAN
IMMUNODEFICIENCY VIRUS AND THE
ACQUIRED IMMUNODEFICIENCY SYNDROME**

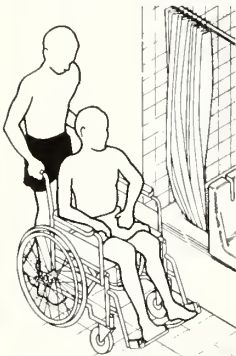


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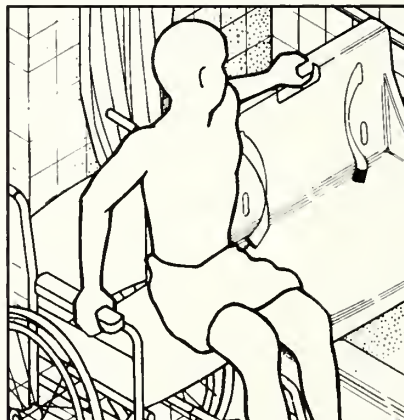
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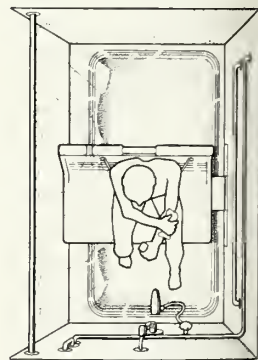
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President's Page

BUSINESS "EFFICIENCY" AND OUR ROLE AS "HEALERS"

These days every journal on practice management speaks of increasing productivity. They say that, by delegating minor problems to physician extenders and by limiting our conversations to an efficient minimum, we can see more patients.

I can certainly see more patients by sticking to the presenting complaint, not looking through charts for previous problems, not asking about family situations, not asking how a child is doing in school, or not asking a wife or a husband how they are getting along; but what will I accomplish if I do this? If I have sold my practice, my new boss will be happy with my production and I may get home earlier. I will probably make more money, something which is always nice, but what will I have lost? I think a great deal, especially the opportunity to discover unresolved problems. I will not identify the problem student and why he/she is having trouble at school or at home. I will not identify the wife who is living in an abusive relationship, or the middle-aged man who is under great stress or the old man who is depressed. In this productivity game, there is no doubt that our patients will be the biggest losers.

I can quickly give pain medicines, H2-blockers or muscle relaxants for the headaches, stomach aches, or back aches. But if I treat only the symptoms and do not rule out the possibility of other underlying causes, the problem will only continue and grow worse. I know from experience that some patients will readily tell me about their physical ailments but cannot bring themselves to talk about other problems without encouragement. Often they wait until the last moment to talk about what really is the matter. How many times have I seen a patient who has been scoped from both ends but has never been asked the necessary questions which might point to depression, abuse or stress. How many times have I seen a patient with multiple symptoms who has had very expensive workups, but has never been looked at as a person with possible psychological problems which could explain the symptoms.

We must talk to our patients. We must take the time to know the patient and his/her particular circumstances. There is no code to reimburse us for spending a few more minutes with each patient to discover potential problems or unmask existing ones, but as physicians, we owe this sort of attention to our patients. To practice this kind of medicine will in the long run, do exactly what practice management experts would have us do – deliver cost-effective medicine. If we can identify underlying problems which will not respond to lab tests, procedures and MRIs, but which might respond to other kinds of therapy, we can hope to satisfy both the business demands of "efficiency" and also to fulfill our time-honored role as "healers."

Benjamin E. Nicholson, M. D.
President

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INFECTION AND DISEASE DUE TO HUMAN IMMUNODEFICIENCY VIRUS AND THE ACQUIRED IMMUNODEFICIENCY SYNDROME*

BOSKO POSTIC, M. D.**

PHILLIP A GREEN, M. D.

CHARLES S. BRYAN, M. D.

In the early 1980s cases of Kaposi's sarcoma and *Pneumocystis* pneumonia began to appear among male homosexuals who were not known previously to be immunodeficient. By immunologic tests, patients showed an impressive depletion of the thymus-derived lymphocytes, particularly the CD4 helper cells. Therefore, the disease was initially called GRID for Gay Related Immunodeficiency. By 1984, cases of this new disease appeared also in recipients of transfused blood, hemophiliacs receiving clotting factors, and intravenous drug users. Therefore, the name acquired immunodeficiency syndrome (AIDS) was adopted. The disease was recognized to carry a high, possibly 100 percent, lethality.

In 1983 scientists at the Pasteur Institute in Paris, France, led by Guy Montagnier, isolated a human retrovirus, which they named lymphadenopathy associated virus (LAV). By 1984,

Robert Gallo and coworkers at the National Institutes of Health in Bethesda, Maryland, U.S.A., also isolated a retrovirus, called initially HTLV-III, for human lymphotropic virus III. These scientists had previously isolated, between 1978 and 1981, leukemia-related viruses HTLV-I and HTLV-II. Further research showed that LAV and HTLV-III were one virus, which was renamed HIV-1 for human immunodeficiency virus. A related virus was later isolated from certain patients with clinical presentation of AIDS from Western Africa and was called HIV-2.

In 1985 a serologic test for antibodies to HIV was introduced and applied for screening human blood for transfusion. This resulted in a safer blood supply, reducing significantly the transfusion-associated HIV infection.

Within a few years of the appearance of cases of AIDS, the HIV infection and disease appeared also in children. The transmission was either transplacental or perinatal.

*From the Department of Medicine, University of South Carolina School of Medicine, Columbia.

**Address correspondence to Dr. Postic at 2 Richland Medical Park, Suite 502, Columbia, SC 29203.

THE ETIOLOGY OF AIDS

HIV causes AIDS. The virus can be isolated from close to 100 percent of cases. A tragic confirmation of the etiology of AIDS was found in the recipients of transfused blood, hemophiliacs, infants born to HIV-infected mothers and the rare health care workers, victims of needle stick accidents. The sexual transmission of HIV was documented in modern epidemiologic studies.

HIV is an RNA-containing virus belonging to the lentivirus family of retroviruses. HIV is capable of producing a cytopathic effect in cultured lymphocytes, whereas other retroviruses such as HTLV-I and HTLV-II tend to transform infected cells, hence their tumor-producing capacity.

HIV is approximately 100 nanograms in diameter and contains two distinct parts: the envelope of the virus and its core. Biologically and medically important subunits in the envelope are the glycoproteins 120 (gp120) and 40 (gp40). The core of the virus contains the genome that encodes for structural proteins (GAG), the polymerase enzyme (POL) and the envelope proteins (ENV). During infection, the immune system creates antibodies directed both to the envelope and the core of the virus.

The main cellular target of the virus is the CD4 helper T lymphocyte, but HIV is capable of infecting other cells: megakaryocytes, peripheral white blood cells, follicular dendritic cells in the lymph nodes, epidermal Langerhans cells, astrocytes and other glial cells, cytotoxic lymphocytes, known as CD8 cells, cells of the cervix of the uterus, rectal mucosa and those of the retina.

EPIDEMIOLOGY

The only reservoir for HIV is the human being. The infected person is capable of transmitting the infection either by heterosexual or homosexual (for men) contact. This may also occur by the transfer of blood containing HIV, by either transfusion, or by contaminated needles used by intravenous drug users infected patients. An HIV-infected mother may infect her fetus/infant in utero, or perinatally, in up to

40 percent of cases. Rarely, infection may occur also through the mother's milk.

According to the World Health Organization, the greatest reservoir of cases of HIV infection is in Sub-Saharan Africa, where up to eight million cases are estimated. Significant reservoirs exist in North America also, with more than one million cases, Latin America and the Caribbean, with the estimate of cases being 1.5 million, and in the South and Southeast Asia, also with 1.5 million or more infected persons. Western Europe is considered to have about 500,000 HIV-infected humans, while Eastern Europe and Central Asia have around 50,000. These figures relate to the mid-1993 period.

PATHOGENESIS OF HIV INFECTION AND DISEASE

An immunocompetent person acquires the infection either through sexual contact or other modes of transmission. Infection means the entry of the virus into the body, its replication in susceptible cells, and the immune response to it. Antibody to HIV-I appears in the infected individual on the average after two months following infection. By six months, more than 90 percent, and by a year more than 99 percent, of the infected acquire demonstrable antibodies.

Some HIV-infected individuals experience an acute HIV syndrome within the first six months of infection. Following this period starts a clinical latency that may last, for five to 10 years. During this period the CD4 T-lymphocytes fall in number, but this may not be observed, since many patients are symptom-free. The host does mount a reasonably effective, although noncurative, response.

When the CD4 number falls below 500, constitutional symptoms such as fever, weight loss, sweats, or diarrhea may occur. At CD4 lymphocyte counts below 200, major opportunistic infections start occurring, and this stage of HIV disease represents AIDS. The outcome is almost uniformly fatal, and it may take 10 or even more years from infection for a patient to succumb to AIDS. A small subset of patients may demonstrate stable clinical and immunologic findings for 10 or more years after docu-

mented infection ("long-term survivors").

Viremia occurs at a higher magnitude during the first six months following infection, and late in the course of disease, usually after many years. During the long clinical latency period, the virus tends to localize in the peripheral lymph nodes, particularly the follicular dendritic cells. Later in the course of disease, the lymph nodes become cytopenic, and the virus escapes again into the bloodstream.

The mechanism of T-cell death is very complex. There is a direct cytotoxic effect of the virus. Autoimmunity also contributes to the T-cell depletion. A form of programmed cell death, known as apoptosis, is thought to play a role in the progressive decline of the CD4 cell reservoir.

Even before significant CD4 depletion, functional abnormalities of the CD4 T-cells can be detected. This consists of diminished proliferative responses to an antigen, failure to recognize previously encountered antigens, and a deficiency in the lymphoid mitogenic responses.

HIV infection also involves the CD8 T-cells, known as cytotoxic or cytotoxic cells. Their number decreases early, within three to four weeks after infection, but usually there is a recovery. In the late phase of AIDS, when the opportunistic infections are more frequent, the CD8 cells also undergo depletion.

HIV replicates in monocytes and macrophages also. A deficient response to inflammation results. The cytokine production becomes unbalanced. T-helper-1 (TH-1) lymphocytes direct cellular immunity and make interleukin-2 (IL-2) and gamma interferon. TH-2 cells direct antibody production and make IL-4, IL-5, IL-6 and IL-10. B-cell dysfunction is due to the TH-1/TH-2 imbalance leading to hypergammaglobulinemia. Due to the deregulated antibody production, HIV-infected patients experience allergies to drugs and to environmentally occurring antigens. In sum, HIV infection produces an immunodeficiency which affects most cell types involved in the response to infection. HIV replicates persistently in the tissues of the infected person, particularly the lymphoid organs. This leads to a

chronic depletion of immune competence. The infected person is then vulnerable to many opportunistic agents, most of which represent internal relapses of past, arrested infections. An example is tuberculosis, a chronic infection, where in the absence of HIV infection, in the majority of infected persons, the immune system is capable of controlling the infection for years. In contrast, in HIV-infected persons, the profound deficit in immune cells, CD4, CD8, the monocyte macrophage system, and the B lymphocytes, leads to serious, life-threatening infections, such as *Pneumocystis carinii* pneumonia (PCP), cerebral toxoplasmosis, tuberculosis and others.

CLINICAL ASPECTS OF HIV DISEASE AND AIDS

The **acute retroviral syndrome** may occur within weeks of infection and presents as:

1. a heterophile antibody-negative mononucleosis.
2. an influenza-like illness without the respiratory component, but occasionally with a maculopapular rash which is faint and centripetal.
3. aseptic meningitis in a few cases.

This acute retroviral illness occurs in the minority of the infected persons, while the majority are asymptomatic.

Years after the infection, **constitutional symptoms** such as fatigue, malaise, episodic fever and night sweats, anorexia and weight loss may follow.

When the CD4 count drops below 500, **oral hairy leukoplakia** may appear. These are white spike-like lesions at the lateral edges of the tongue. They represent crystals of Epstein Barr virus, which relapse from a dormant stage. The condition is aesthetically damaging; otherwise it carries no symptoms.

Herpes zoster may appear in many individuals who are HIV-infected, irrespective of age. Such attacks result from immunodeficiency, promoted by HIV, leading to a relapse of varicella-zoster virus from a latently infected ganglion. Not every case of herpes zoster in a younger individual points to HIV infection.

Nevertheless, a person under 50 presenting with herpes zoster should have a serologic screen for HIV antibodies.

Herpes simplex virus (HSV) causes, in patients with advanced AIDS, painful perianal or genital ulcers, lasting more than a month. Frequently, there is an associated, even more painful herpes proctitis. It is diagnosed by anoscopy or sigmoidoscopy and virus culture, yielding usually HSV type 2, or by the characteristic giant cells on an imprint slide ("Tzanck preparation"). The diagnosis may also be reached by a favorable response to an empiric trial with acyclovir: 400 mg every four hours for 10 days, followed by lifelong 400 mg twice daily. HSV type 1, occasionally type 2, may cause oropharyngeal vesicles developing into lasting ulcers. As is the case with most opportunistic diseases, mucocutaneous HSV is mostly an internal relapse, not a new infection.

Since HIV is a sexually-transmitted disease, other such diseases tend to coincide with HIV/AIDS. Of these, **syphilis** is probably the most important. Early neurosyphilis, within the first two years of a syphilitic infection, is characterized by meningitis, cranial nerve abnormalities, or a stroke. A seizure disorder in a HIV-infected individual may also be due to neurosyphilis. Without HIV, late manifestations of neurosyphilis are manifested, on the average, later than 15 years from infection with *Treponema pallidum*. In contrast, in HIV-infected individuals late neurosyphilis may be seen within four years. The diagnosis of neurosyphilis in HIV-infected individuals is not simple. It is confirmed with the demonstration of circulating antibodies to *Treponema pallidum*, and the recognition of these antibodies by the VDRL test in the cerebrospinal fluid (CSF). This test is specific, but not very sensitive. The most frequent laboratory abnormality is pleocytosis of the CSF, consisting of lymphocytes and monocytes, but the sensitivity of the increased cell count is below 70 percent. The diagnosis may be achieved by the demonstration of spirochetes with special stains in the spinal fluid or in nervous tissue, as well as by the polymerase chain reaction for the treponemal DNA.

Tuberculosis may occur at any stage of infection due to HIV. A tuberculin reaction may be suppressed in individuals whose CD4 counts are lower than 500. Therefore, it is important to date the tuberculin test to the CD4 count. A high index of suspicion should be exercised with an apparent pneumonia not responding to otherwise-effective antimicrobial treatment. The recognition of mycobacteria in the sputum, by smear and culture, calls for specific therapy (see below). Cases of tuberculosis may be atypical in an HIV-infected individual: in more than 25 percent of cases, disseminated disease is seen. The chest x-ray may be clear, yet endobronchial tuberculosis may be at hand. The appearance of the pulmonary radiogram may or may not show the classical subclavicular pattern of reactivated tuberculosis. Pulmonary tuberculosis may present as noncavitary lesions in any lung segment.

Acute, progressive and disseminated **histoplasmosis** may involve the HIV-infected patient, usually at the stage of AIDS. Fever is the most frequent sign. Oral and genital ulcers, lymphadenopathy and hepatosplenomegaly, and a maculopapular, erythematous rash on the face, trunk and extremities, are possible associated findings. The diagnosis may be made by finding characteristic yeast cells in the polymorphonuclear white cells and monocytes on the blood smear. The blood and/or bone marrow cultures are frequently productive, as are biopsies of the involved organs. This includes the central nervous system lesions, which may resemble the rimmed lesions of toxoplasmosis. A heat stable polysaccharide antigen in the urine and serum is diagnostically useful. This test, a solid phase radioimmunoassay, is available in a specialized research laboratory. The urine antigen is found in 90 percent of AIDS patients with disseminated histoplasmosis. Treatment of this infection calls for amphotericin B, at 0.7 to 1.0 mg/kg a day intravenously, to reach a cumulative dose of 2.5 gm, if tolerated. Maintenance, long-term treatment with 200 mg of itraconazole, twice daily, is required to prevent relapses.

At earlier stages of HIV infection, as well as

later, a generalized, mostly asymptomatic **lymphadenopathy** may occur. It tends to be cervical, axillary, as well as inguinal, and is usually symmetric. An asymmetric lymphadenopathy raises the suspicion of a lymphoma.

Of the **dermatologic manifestations**, seborrheic dermatitis is frequently seen. Symptoms and signs are diverse and relate to the exacerbation of underlying skin conditions, such as psoriasis, opportunistic tumors, Kaposi's sarcoma, as well as opportunistic infections: cutaneous cryptococcosis, mucocutaneous histoplasmosis, molluscum contagiosum, genital warts, herpes zoster, and herpes simplex virus. The latter may present as blisters or ulcers that do not heal readily. A pruritic eruption is frequently seen, also. Its main effect is annoyance.

Of the **mucous membrane manifestations**, oral and pharyngeal candidiasis is the most frequent. In most cases, it can be controlled with antifungal agents. **Aphthous stomatitis** is bothersome in HIV-infected persons. Treatment with steroids is resorted to in cases that are painful and interfere with the patient's nutrition. **Genital candidiasis** is also frequently seen, as is recurrent genital herpes, condyloma acuminatum, and related to the latter, uterine cervical intraepithelial neoplasia and carcinoma.

The **laboratory findings** frequently seen in patients with HIV disease consist of anemia and thrombocytopenia. Leukopenia is common, particularly neutropenia, and later, lymphocytopenia. The platelet abnormalities, due to autoimmunity, are capricious as to their appearance and occasional spontaneous improvement. The main laboratory abnormality is the CD4 lymphocytopenia, which is also the best method to judge the remaining immune reserve of the infected individual. Hypergammaglobulinemia is due to lack of helper function by CD4 lymphocytes. It is polyclonal by electrophoretic analysis of serum proteins. Elevated blood urea nitrogen or serum creatinine, proteinuria, and hypoalbuminemia point to renal involvement leading frequently to failure. The pathology consists of a focal sclerosing glomerulonephritis, and is seen particularly in persons of African origin infected with HIV.

Wasting syndrome, a profound loss of more than 15 percent of body weight, occurs late in AIDS. The presence of diarrhea or fever lasting over one month is a diagnostic requirement for this syndrome. Laboratory abnormalities include hypocholesterolemia and hypertriglyceridemia. They may relate to the effect of cytokines, particularly tumor necrosis factor (TNF).

When the CD4 count falls below 200, major opportunistic infections occur. Of these, in persons who do not receive specific prophylaxis (see below), ***Pneumocystis carinii* pneumonia (PCP)** is the most frequent. Characteristically, this is a pneumonia slow in onset, starting with a low-grade fever and cough over several weeks, progressing to sustained fever and hypoxemia. The chest x-ray most frequently consists of reticular nodular infiltrates, but other presentations such as unilateral pneumonia and/or tumor-like appearance on the chest x-ray may also be present. The latter is seen in persons who undergo prophylaxis with pentamidine by inhalation, due to uneven distribution of the drug, which may miss poorly ventilated lung segments such as the apices.

When the CD4 lymphocyte count is under 200, an approach is suggested to diagnose an opportunistic pulmonary infection and/or a bacterial, community-acquired pneumonia:

1. Sputum should be induced by nebulization with hypertonic (10 percent) saline and examined by:
 - a. gram stain, bacterial culture
 - b. stain, culture for mycobacteria
 - c. stain, culture for fungi
 - d. cytology for *Pneumocystis carinii*
2. Empiric therapy, based on above findings, directed to a bacterial pathogen or PCP.
3. When the patient's condition is serious at outset, or empiric therapy fails within 72 hours, the diagnosis requires an invasive method: bronchoscopy, bronchoalveolar lavage, transbronchial biopsy or a pleural tap and biopsy, if applicable. The examination of the biopsy should include histology, with appropriate stains and microbiologic tests as above. In sum, pulmonary disease

in a compromised patient calls for a definitive diagnosis which then leads to definitive therapy.

AIDS-related tumors consist of non-Hodgkin's lymphoma, central nervous system lymphoma and Kaposi's sarcoma. The latter is an endothelial tumor and occurs, almost exclusively, in HIV-infected male homosexuals. Cervical neoplasia, as previously mentioned, should be screened for by semiannual Pap smears.

Cerebral toxoplasmosis of the brain is an important opportunistic infection occurring in people who are HIV-infected, very depleted in their CD4 reserve (under 100), usually presenting with a headache, focal neurological defect or seizure. On CT scanning of the head, one usually sees a ring-enhancing lesion. Definitive diagnosis can be accomplished by an aspirational biopsy through a burr hole. This is rarely resorted to, since a presumptive diagnosis may be reached by demonstrating anti-toxoplasma IgG antibodies in the serum, reflecting a previous immune experience, and a characteristic radiological (CT) picture showing ring lesions brought out by contrast injection. The diagnosis is strengthened by a favorable response to drugs inhibitory to *Toxoplasma gondii*.

Another important central nervous system (CNS) infection is **cryptococcosis**. This complication of AIDS presents with a progressive headache, low-grade fever, but infrequently with a stiff neck otherwise characteristic of meningeal infections. Therefore, when a patient presents with the above symptoms and with a CD4 count lower than 200, a lumbar puncture is necessary. In addition to the examination of the cerebrospinal fluid (CSF) for cells, protein and glucose, an India ink preparation should be done to visualize the cryptococcal forms. Since only 65 percent of CSF samples from cases are India ink positive, the finding of cryptococcal antigen beyond the titer of 1:8 in the CSF is diagnostic. Conversely, CSF found free of cryptococcal antigen essentially excludes this infection. Ultimately, a positive culture for *Cryptococcus neoformans* from the CSF sample confirms the diagnosis and monitors the

effectiveness of treatment. Note that the recognition of cryptococcal antigen may take a few hours, while the fungal culture requires weeks.

Late in the course of AIDS, up to 30 percent of patients develop a fairly abrupt and progressive loss of cognitive ability. This may be coupled with slow movements, impaired balance, ataxia and spasticity. **AIDS dementia or encephalopathy** is then at hand. The diagnosis is made by excluding opportunistic infections and tumors of the CNS by scanning and CSF examination. Many of the affected patients become bed-ridden, incontinent of urine and feces. Within six months, the case fatality rate reaches over 50 percent. AIDS encephalopathy may be associated with intense, steady pain of various body parts. Patients may require continuous intravenous morphine. Peripheral neuropathy and myelopathy may appear by themselves or coexist with AIDS dementia-encephalopathy.

In HIV disease, and particularly AIDS, varied **gastrointestinal manifestations** occur. The most frequent is ***Candida* esophagitis**. It presents with dysphagia and a dull retrosternal pain following solid food ingestion. When these symptoms coincide with oral-pharyngeal candidiasis, one makes a presumptive diagnosis of *Candida* esophagitis.

The esophagus may also be attacked by herpes simplex and cytomegalovirus. The diagnosis here is based on biopsy results. The viral ulcerations of the esophagus are also characterized with odynophagia in addition to dysphagia.

An **idiopathic esophagitis** occurs in patients with advanced AIDS. When fungal, herpes simplex virus, and cytomegalovirus esophagitis are excluded by endoscopy, large shallow ulcers in the esophagus are called idiopathic. They may be close in pathogenesis to aphthae, and respond to prednisone therapy. The course should be at least one month, starting at 60 mg of prednisone a day, scaled down to the daily doses to 40 mg, 20 mg, etc. Antacids and local medications, such as sucralfate, are also helpful.

Diarrhea is frequent in the context of HIV disease/AIDS. Intestinal salmonellosis may present alone and as enteric fever, with stool and

frequently, blood cultures yielding a non-typhoid species. In either case, effective treatment choices are: a third generation cephalosporin (ceftriaxone, cefotaxime), ciprofloxacin, or trimethoprim-sulfamethoxazole.

Of the parasitic diarrheas, **cryptosporidiosis and microsporidiosis** are the most troublesome, since the treatments are only partially effective. Spontaneous recovery from cryptosporidial infection may occur when the CD4 count is above 200. A non-absorbable aminoglycoside, paromomycin, or the macrolide azithromycin, may promote recovery in some cases. Microsporidial enteritis is hard to diagnose and treat. Occasionally, metronidazole may offer temporary relief. The antiparasitic drug albendazole may be effective here. In many cases of AIDS-associated diarrhea, subcutaneous injections of a synthetic somatostatin are required for control, effected by the inhibition of the intestinal sodium pump.

To sort out multiple causes of AIDS-associated diarrhea, the liquid stool specimen should be examined for:

1. ova and parasites
2. intestinal bacterial pathogens (by culture)
3. *Clostridium difficile* toxin
4. smear and culture for mycobacteria
5. smear for *Cryptosporidium* (via a modified acid-fast stain)
6. smear for microsporidia by the trichrome stain

When the above efforts fail and the cause of diarrhea remains uncertain, endoscopic biopsies are needed: rectal biopsy may yield the diagnosis of cytomegalovirus colitis, Kaposi's sarcoma, condyloma acuminatum, or herpes simplex virus. By jejunal biopsy, microsporidiosis and giardiasis may be disclosed.

Hepatic disease is seen in many HIV-infected patients. Due to similar transmission routes, **hepatitis B and C viruses** frequently co-exist with HIV in intravenous drug users and recipients of contaminated blood transfusions. Paradoxically, symptomatic hepatitis B is not enhanced in HIV-infected patients, since this liver disease is accentuated in immunocompetent individuals. Conversely, the clearance of

hepatitis B viremia (antigenemia) is impaired by the immunodeficiency produced by HIV. Likewise, the response to hepatitis B vaccine may be impaired, as expected.

Hepatitis C virus injury may be accelerated in HIV disease, including the development of chronic active hepatitis and cirrhosis. Interferon alpha (IF) represents a treatment modality at three million units three times a week subcutaneously, for six months. Unfortunately, treatment with IF produces fatigue, fever and leukopenia, as does HIV disease. Therefore, this treatment may not be well tolerated and should be individualized.

Sclerosing cholangitis presents with fever, abdominal pain and a pattern of obstructive jaundice. It is diagnosed by endoscopic cholangiography. This complication may be due to disseminated *Mycobacterium avium* or cryptosporidiosis. Empiric treatment against the former infection may be palliatively effective.

Animal contact, particularly with domestic cats and dogs, is important. *Rochalimaea henselae* and *R. quintana* (related to the Rickettsiae) have been associated with cat scratch disease, which may disseminate. These agents also cause a generalized febrile illness with abdominal pain, painful erythematous skin plaques and nodules, lymphadenopathy and hepatosplenomegaly. This new disease was named **bacillary angiomatosis**, or peliosis hepatis when involving the liver. Fortunately, treatment with either erythromycin or tetracycline is effective. Since the diagnosis of these Rickettsia-like agents is by blood culture, or serology, processed in specialized laboratories, empiric treatment with the above antibiotics may be indicated. Patients respond within a week, but treatment requires two months to improve the liver function tests.

In advanced cases of AIDS, when the CD4 count is below 50, disseminated *Mycobacterium avium* complex (MAC) infection occurs. The signs are systemic, such as excessive sweating and fever, hepatosplenomegaly, major weight loss, and diarrhea. The stool may contain demonstrable acid-fast bacteria by smear or culture. In many instances, MAC can be iso-

lated by blood culture, but the incubation period for such is up to threemonths. Therefore, a therapeutic intervention is resorted to when disseminated infection with MAC is suspected.

Another infection late in the chain of events in the profoundly immunosuppressed AIDS patient, with a CD4 count below 50, is **cytomegalovirus (CMV) retinitis**. Visual abnormalities developing over several weeks lead to blindness. By ophthalmoscopy, perivascular exudates and hemorrhages progress rapidly, unless specific therapy is applied.

DIAGNOSIS OF HIV/AIDS

The diagnosis of HIV infection is accomplished by the recognition of specific antibodies to HIV. The usual specimen is the serum. The antibodies to HIV are recognized in most laboratories by the ELISA method. If the reaction is positive, the serum is tested for antibodies to the envelope and core proteins of HIV. Of the former, anti-gp120 and anti-gp40 are prominent, and of the latter, anti-p24. These subunit antibodies are recognized by the Western blot technique. Antibodies to both envelope and core proteins must be present for a positive test. If only one of these is positive, the reaction is indeterminate.

The sensitivity of the above method is 99 percent, and the same applies for specificity. By sensitivity one means the ability of a test to detect the infection, and by specificity, to exclude HIV.

As mentioned, the virus can be cultured in suspensions of human lymphocytes, but this is a difficult method, not yet applied in clinical medicine.

Circulating p24 antigen occurs in early or late phases of HIV/AIDS. This test is not sensitive, but is specific. A very sensitive and specific test is the recognition of HIV-1-DNA by PCR (polymerase chain reaction) and HIV-1-RNA, also by PCR. With HIV-1-RNA, the PCR yields the number of copies of virus per subunit of blood. Testing for HIV by PCR is helpful in cases with indeterminate serologic finding (see above), for evaluating experimental antiviral therapy, and diagnosing HIV infection in

infants, whose circulating antibodies are maternal. Unfortunately, the PCR test is expensive and available only in special laboratories.

The laboratory studies for HIV-infected patients are attached as a guide (Table 1a, 1b). Tests are divided into essential, such as the CD4 count, and desirable, such as toxoplasma serology. These tests stage the HIV-infected patient and guide prophylaxis and therapy.

CLASSIFICATION OF HIV INFECTION, DISEASE AND AIDS

HIV infection, disease and AIDS are parts in a chain of events in the infected individual. Complex classifications systems have been introduced. The currently used Centers for Disease Control classification is offered in an abbreviated form (see Table 2). Here, "1" refers to the CD4 reserve of 500 or greater per milliliter of serum, "2" for 200-499, and "3" less than 200. Regarding clinical categories: "A" is the asymptomatic HIV infection, and "B" the symptomatic one, formerly the AIDS-related complex, "C" encompasses diseases with AIDS-defining tumors or opportunistic infections, presumptively or definitively diagnosed. Diseases in the clinical category of "C", irrespective of the CD4 count, qualify as cases of AIDS. Even if these diseases are not present, a CD4 count of less than 200 is also diagnostic for AIDS.

The World Health Organization's (WHO) definition of an adult case of AIDS is based on clinical grounds alone. Therefore, it is suitable for developing countries. According to WHO, the major signs of AIDS are: > 10 percent weight loss, diarrhea > one month, fever > one month. Minor signs are: cough > one month, generalized pruritic dermatitis, recurrent herpes zoster, oropharyngeal candidiasis, progressive, disseminated herpes simplex, generalized lymphadenopathy. The presence of at least two major and one minor sign means AIDS. Also diagnostic of AIDS are cryptococcal meningitis and disseminated Kaposi's sarcoma.

DIFFERENTIAL DIAGNOSIS

From the natural history of HIV infection, disease, and its late stage of AIDS, it is clear that

TABLE 1a
BASELINE LABORATORY STUDIES
FOR PATIENTS FOUND TO BE INFECTED WITH HIV*

ESSENTIALComment

- | | |
|---|--|
| 1. CD4 lymphocyte count
(quantitative T lymphocyte studies) | Essential to guide treatment and estimate prognosis. |
| 2. PPD (tuberculin skin test, Mantoux method, 5 t.u.) | Date the reaction to the CD4 count. |
| 3. VDRL (RPR) (serology for confirm by MHA-TP syphilis), if positive, | MHA-TP = Microhemagglutination-Treponema pallidum |
| 4. Women: pelvic examination, Pap smear, pregnancy test | Cervical cancer is AIDS-defining! |

*Anti-HIV found by ELISA and confirmed by Western blot.

TABLE 1b
BASELINE LABORATORY STUDIES
FOR PATIENTS FOUND TO BE INFECTED WITH HIV*

DESIRABLEComment

- | | |
|--|---|
| 1. Hepatitis B serology | Particularly for IVDA. |
| 2. Chest x-ray | Baseline needed. |
| 3. CBC, diff.; blood chemistry panel, amylase | Monitors the safety of treatment. |
| 4. Toxoplasmosis serology (IgG IFA) | CNS toxoplasmosis occurs at 30% in seropositive and at < 10% in seronegative patients with CD4 < 100. |
| 5. Cytomegalovirus serology (IgG IFA) | > 98% positive in male gays; seronegatives to receive a blood transfusion from the like donor; risk of CMV retinitis in seropositives with CD4 < 100. |
| 6. HIV p24 antigen level | Predicts progression of HIV disease; monitors efficacy of antiviral treatment. |
| 7. HIV-1-DNA-PCR** | Detects latent infection with HIV. Sensitive test to follow a nosocomial accident and in infants. |
| 8. HIV-1-RNA-PCR | Yields the number of HIV copies per mm ³ of blood; useful for monitoring experimental antivirals. |
| 9. G6PD (glucose 6 phosphodehydrogenase (screen) | Obtain prior to using Dapsone for PCP prophylaxis. G6PD deficient patient may develop hemolytic anemia while on Dapsone. |
| 10. Plasma erythropoietin (EPO) | For anemic patients with Hb < 10 g/dl. Those with EPO < 500 units benefit from synthetic EPO injections. |

* Anti-HIV found by ELISA and confirmed by Western blot.

** Polymerase chain reaction.

TABLE 2

Classification for HIV Infection, Disease and AIDS Case Definition for Adults¹Clinical Categories²

CD4 Cell Count	(A)	(B)	(C)
(1) 500/mm ³ or greater	A1	B1	C1
(2) 200 to 499/mm ³	A2	B2	C2
(3) Less than 200/mm ³	A3	B3	C3
	Asymptomatic HIV infection	Symptomatic, not (A) or (C) conditions (formerly AIDS-related complex)	AIDS-indicator (opportunistic) conditions
	Acute (primary) HIV infection Persistent generalized lymphadenopathy Acute retroviral syndrome	Candidiasis, oral or recurrent vaginal Cervical dysplasia Constitutional symptoms (such as fever or diarrhea) for more than 1 month. Hairy leukoplakia, oral Herpes zoster infection Idiopathic thrombocytopenia purpura Listeriosis Pelvic inflammatory disease	Candidiasis, pulmonary or esophageal Cervical cancer Cryptococcosis extrapulmonary Cryptosporidiosis Cytomegalovirus, retinitis or esophageal Histoplasmosis Isosporiasis Kaposi's sarcoma Lymphoma Mycobacteria, avium, disseminated Mycobacteria, tuberculosis <i>Pneumocystis carinii</i> Pneumonia, recurrent Progressive multifocal leukoencephalopathy Salmonellosis, recurrent

¹Modified from Centers for Disease Control and Prevention, Atlanta, Georgia, U.S.A. 1993 revised classification system for HIV infection and extended surveillance case definitions for AIDS among adolescents and adults. Table 1 Morbidity and Mortality Weekly Report 1992;41:1-19.

²This is an abbreviated list; all conditions under C, B3 and A3 are classified as AIDS since January 1, 1993.

one is dealing with a chronic infectious disease which favors secondary, opportunistic infections and tumors. The differential diagnosis for each stage would be different.

For the early retroviral syndrome, infectious mononucleosis would be the main alternative diagnosis. The etiology can be settled with specific serologic tests for Epstein Barr virus antibodies, CMV, or those to HIV.

Since aseptic meningitis can occur with many diseases such as enteroviruses or secondary syphilis, the list of possible agents is long and encompasses rare conditions such as *Listeria* meningitis, as well as the more common ones mentioned above.

During asymptomatic and symptomatic HIV disease, chronic lymphadenopathy caused by mycobacteria or lymphoma must be considered. The latter tends to be localized and its growth is more rapid.

When the CD4 count falls below 200, opportunistic infections occur affecting many organs. It is not practical to engage in an infinite list of diagnostic possibilities. Hematologic abnormalities such as anemia, leukopenia, both neutropenia and lymphopenia, all suggest the possibility of an underlying HIV infection.

PROPHYLAXIS AND THERAPY

An overall HIV/AIDS plan is presented in Table 3.

All infected patients should receive a polyvalent pneumococcal vaccine, usually one such administration suffices. Influenza virus A and B vaccines are applied annually. They are modified annually according to the antigens of the circulating influenza strains. *Haemophilus influenzae* B (HiB) vaccine may also be useful. Hepatitis B vaccine is appropriate for the non-immune patient with ongoing risk of exposures.

Many HIV infected patients are either immuno-deregulated or deficient, hence, they may not develop antibodies upon immunization. It is not practical to test recipients for immune response to a vaccine.

If the patient is tuberculin reactive, a thorough work-up has to be done to ascertain the stage of tuberculosis. A baseline chest x-ray is

useful, but endobronchial tuberculosis may coexist with HIV infection yet not be detected radiographically. Therefore irrespective of the chest x-ray finding, a sputum sample should be induced and submitted for smear for acid-fast bacteria (AFB), followed by culture.

Antituberculous treatment or prophylaxis is then applied as applicable. Treatment is necessary for all infectious cases. Antituberculous treatment in the HIV/AIDS era consists of combined multi-drug therapy in the following daily doses: isoniazid (INH) 300 mg, rifampin 600 mg, pyrazinamide (PZA) 1 to 1.5 gm and ethambutol, 800 to 1600 mg, depending on the patient's weight (15 mg/kg). PZA is given for two months only; the remainder of the drugs are used for nine to 12 months. For patients who are toxic, or in whom a multidrug-resistant *M. tuberculosis* is suspected, streptomycin 1 gm IM injection daily, or 1/2 gm for those over 55 years of age, is applied for periods up to two months. The patient's renal function must be intact for this dosing. Tuberculin reactors in whom active tuberculous disease is not found are treated with Isoniazid for prophylaxis (technically "preventative therapy").

Prophylaxis and treatment options depend on the immune status. Thus, for patients with CD4 counts below 500, antiretroviral treatment with AZT (zidovudine) is given, usually in 500 – 600 mg per day in three divided doses postprandially. Patients with CD4 counts between 200 and 300 receive either monotherapy with AZT or ddl (didanosine) or combined therapy consisting of AZT and ddC (zalcitabine), AZT and ddl. The average dose of ddl for an adult is 200 mg twice a day, before meals. ddC is given at 0.75 mg three times a day postprandially, or if one is concerned about the possible peripheral neuropathy, the dose may be lowered to 0.375 mg three times daily.

Immunosuppressed patients with CD4 counts below 200 receive the same treatment as those in the preceding category above. Added to these options is monotherapy with D4T (stavudine), usually at 40 mg twice daily, for patients who are intolerant of failed therapy with the antiretrovirals above. Treatment must always

TABLE 3*
HIV/AIDS CARE PLAN 1995
ALL INFECTED WITH HIV

VACCINES:

PNEUMOCOCCAL
INFLUENZA VIRUS A & B
H. INFLUENZAE B

IF TUBERCULIN REACTIVE:

AFB SMEAR, CULTURE OF SPUTUM
CHEST X-RAY
ANTI-TB TREATMENT OR PROPHYLAXIS – AS APPLICABLE

PROPHYLAXIS AND TREATMENT OPTIONS ACCORDING TO IMMUNE STATUS

CD4 < 500

AZT

CD4 200-300

AZT
DDI
AZT + DDC

CD4 < 200

AZT
DDI
AZT + DDC
D4T

PROPHYLAXIS

TMP-SMX
DAPSONE
AEROSOL PENTAMIDINE

against
pneumocystis
pneumonia

FLUCONAZOLE

against
cryptococcosis

RIFABUTIN
CLARITHROMYCIN

against *M. avium*

TMP-SMX
PYRIMETHAMINE
DAPSONE

against
toxoplasma
(IGG+)

Abbreviations:

AFB = acid fast bacterium
AZT = Zidovudine
DDI = Didanosine
DDC = Zalcitabine
D4T = Stavudine
TMP-SMX = trimethoprim-sulfamethoxazole

*As modified from reference 6.

be individualized depending upon preexisting conditions, previous drug intolerances, and new research data.

Patients with CD4 counts below 200 require prophylaxis against *Pneumocystis carinii*. The most effective drug is trimethoprim-sulfamethoxazole (TMP-SMX) at the daily dose of 160 mg and 800 mg, respectively (i.e. one double-strength tablet). If one is concerned

about anemia, neutropenia, or thrombocytopenia, this drug can be prescribed as one tablet every other day.

The second choice for PCP prophylaxis in the G-6-PD normal patient is dapsone, given as 50 mg twice daily. In the event of intolerance to the above drugs, aerosolized pentamidine, at 300 mg once a month, is applied indefinitely. Its cost greatly exceeds that of the first two

options. Use of an albuterol inhaler may attenuate the cough sometimes caused by aerosolized pentamidine.

Against cryptococcosis, fluconazole in the dose of 100 – 200 mg a day is considered to be prophylactically effective. For patients with a very low CD4 reserve, less than 100 and certainly lower than 50 such cells, rifabutin 300 mg daily, or clarithromycin, 500 mg twice a day, are effective against the disseminated infection due to *Mycobacterium avium* complex.

Patients with a CD4 reserve below 100 cells with anti-toxoplasma (IgG) antibodies may receive prophylaxis with TMP-SMX, dosed as above against PCP. Pyrimethamine is the main drug for treatment of toxoplasmic encephalitis. It is also effective prophylactically, but too toxic for wide usage. Fortunately, dapsone at 50 mg twice a day is also effective as prophylactic therapy against toxoplasma, for persons with evidence of IgG antibodies against this agent.

It may be concluded from the above that the therapeutic approach in treating HIV/AIDS cases consists of (1) antiviral therapy and (2) therapy and prophylaxis against opportunistic infections.

At the time of this writing, no reliably effective and lasting method is available for stimulating immunity and compensating for the immune deficit produced by HIV, despite intense research. Experimental therapy with IL-2 improved modestly the CD4 count in HIV-infected patients with CD4 counts above 200.

Little or no reduction in the HIV load was noted by quantitative virus isolation. Interleukin-12 (IL-12) stimulates TH-1 helper and natural killer cells to produce gamma interferon. It is planned for clinical trials in combination with antiretroviral drugs. Granulocyte colony-stimulating factor and synthetic erythropoietin are useful in modifying the toxic effects of antiretrovirals. Interferon alpha (IF), in massive doses, is effective in the treatment of disseminated Kaposi's sarcoma (KS). The side effects of IF are leucopenia, fever and fatigue. In patients with HIV-1 p24 antigenemia, and free of KS, IF modestly reduced the p24 level. IF, in combination with the antiretroviral AZT, is undergoing clinical efficacy and toxicity trials.

Antiviral therapy against HIV with reverse transcriptase inhibitors (see below) may bring about, transiently, an increase in the CD4 reserve.

ANTIRETROVIRAL DRUGS

The replication of HIV in the susceptible cell, such as the CD4 lymphocyte, proceeds through stages, each potentially vulnerable to antiviral treatment (See Stages below).

Zidovudine (AZT, for azidothymidine) was the first agent, used for the inhibition of HIV replication. Its mechanism of action is considered to be the termination of a growing DNA-chain in HIV biosynthesis, by interfering with the reverse replicase or transcriptase (RT). This enzyme is "packaged" in the HIV virion. The antiviral effect depends on the continuous pres-

STAGE	EVENT	DRUG	COMMENT
1	PENETRATION – UNCOATING	CD4 receptor analogue	Not effective, but harmless in patients
2	REVERSE TRANSCRIPTION: HIV-RNA to DNA	AZT, ddI, ddC, D4T	Only currently marketed drugs
3	HIV DNA (integration, transcription, translation)	TAT (viral gene) antagonists	Theoretically attractive
4	HIV ASSEMBLY AND RELEASE	Protease inhibitors (PI) interferons (IF)	PI appears promising in early trials. IF undergoing trials.

ence of the drug, since antiviral therapy is inhibitory and not virucidal. AZT is well distributed in the body, reaching the cerebrospinal fluid, and is effective in slowing AIDS dementia. A higher daily dose of AZT (1,000 mg) may be required for this indication.

In a patient treated with zidovudine, the virus genome mutates at the locus responsible for the RT gene. Thus, AZT-resistant HIV was isolated from treated patients. In cases of AIDS, this may become clinically significant after six months of treatment.

Didanosine (ddI) is also a DNA-chain terminator. While zidovudine is a structural analog of thymidine, didanosine (ddI) is related to inosine. The third RT inhibitor, zalcitabine (ddC) is a cytosine derivative.

Stavudine (D4T), a fourth nucleoside analog, is given to patients who become intolerant of the above three drugs. This drug is less toxic to bone marrow, but it produces peripheral neuropathy in up to 40 percent of patients. Stavudine may have an antagonistic effect on AZT, which makes it unsuitable for combination therapy. It appears that D4T penetrates well into the central nervous system and may hold some promise in the treatment of AIDS dementia.

Lamivudine (3TC) is a cytosine nucleotide analogue and an RT inhibitor. It holds promise, based on laboratory and clinical experiments carried out in 1994 and 1995 because of: (1) relative lack of toxicity in humans; (2) a persistent antiviral activity despite the emerging drug resistance; and (3) induction of a mutation in HIV strains isolated from AZT-treated patients, which may preserve and/or restore their sensitivity to AZT! Thus, the addition of 3TC helps maintain the anti-viral effect of AZT.

In treated patients, resistance to all drugs active at the RT site occurs in the HIV pool. Patients failing therapy with AZT derived some benefit with a switch to ddI. Monotherapy with ddI or ddC was found to be equal in its effectiveness. Combination of AZT with either ddC or ddI has a favorable effect on the CD4 count, which, hopefully may translate into a clinical benefit. The AZT plus ddC combination is indicated for patients with CD4 counts under

300. The rise in the CD4 levels may extend beyond 12 months, which is twice the length for this immune "honeymoon" produced by AZT alone. The post-prandial eight-hourly dosing of both AZT and ddC promotes patient compliance. Combination therapy with drugs active at different sites, such as AZT with a protease inhibitor, may be more effective and also delay the occurrence of resistance to the antiviral drugs. In principle, multidrug therapy is preferred to monotherapy. An attractive combination would consist of AZT, 3TC and a protease inhibitor. Its efficacy is not yet proven, awaiting the result of clinical trials.

TOXICITY OF ANTIRETROVIRAL DRUGS

The main toxicity of AZT is hematologic. Anemia, particularly neutropenia, appears in a large proportion of patients. Macrocytosis is also seen. Therefore, patients should be monitored by serial, monthly complete blood cell counts. When the hemoglobin falls below 9 grams/dL, and/or the absolute granulocyte count below 1,000/mm³, it is unsafe to continue with AZT.

The main toxicities of ddI and ddC are pancreatitis and peripheral neuropathy. DdI produces more cases of pancreatitis, while ddC more peripheral neuropathy. In that respect, it is similar to stavudine, as mentioned above. These should not be combined, as they may enhance each other's toxicities (see below).

Major opportunistic infections occur at the late stage of AIDS, when many side effects of antiviral therapy, such as anemia and neutropenia may be present. Therefore, with an onset of a major opportunistic infection (O.I.), such as *Pneumocystis pneumonia*, it is prudent to temporarily discontinue antiviral therapy, since a major O.I. is directly endangering the patient's life, and drugs used against O.I.s may add additional toxicities.

TREATMENT OF OPPORTUNISTIC INFECTIONS

The main drug for treating *Pneumocystis carinii pneumonia* (PCP) is trimethoprim-sulfamethoxazole (TMP-SMX). In hypoxemic

patients, this drug has to be administered intravenously at 15 – 20 mg per kg of the trimethoprim component per day, while sulfamethoxazole is always five times the dose of the former. When the partial pressure of oxygen is below 75 mm Hg, intravenous therapy is usually administered. Otherwise, for patients with better oxygenation of the blood, oral TMP-SMX can be given, usually in four daily doses, where the total dose corresponds to that mentioned above. The usual treatment is 21 days. Hypoxemic patients do better if prednisone is added to the treatment. During the first five days, 40 mg twice daily is given, followed by 40 mg daily for five days and 20 mg daily for the remaining 11 days. The addition of a corticosteroid preparation carries a theoretical risk of promoting other opportunistic infections such as tuberculosis. Following recovery from the acute episode of PCP, TMP-SMX is given at 160 – 800 mg daily lifelong, since otherwise relapses can be predicted.

The main toxicity of TMP-SMX is anemia and neutropenia, and occasionally thrombocytopenia. Allergic reactions are frequent. The appearance of a rash, fever, and liver function abnormalities during TMP-SMX treatment indicates a switch to pentamidine.

An alternate treatment for PCP is intravenous pentamidine at 4 mg per kg a day, for 21 days usually. The main toxicity is renal, which dictates the monitoring of renal function during the course. The drug is associated with several other clinical and laboratory side-effects.

When a sulfonamide allergy occurs, trimethoprim, 20 mg/kg daily, divided in six hourly doses, may be combined with dapsone 100 mg daily. Alternatively, clindamycin and primaquine may be combined: clindamycin intravenously at 900 mg every eight hours or 600 mg every six hours, or orally 450 mg four times a day, and primaquine (base) 30 mg daily, orally. Patients receiving dapsone or primaquine should not be G6PD deficient. Atovaquone, 750 mg orally three times a day, is an option for milder cases, free of hypoxemia. Its cost and unpredictable absorption are drawbacks to its use. A 21-day course applies to all treat-

ments.

Trimetrexate, 45 mg/m²/day, may be given to severely ill, hypoxemic patients who fail the above therapeutic regimens. Leucovorin (folic acid) serves as a rescue, since trimetrexate is predictably toxic to the bone marrow. Therefore, leucovorin is given for three additional days after the 21-day long course.

Cryptococcal meningitis is treated in the acute phase with both amphotericin B and fluconazole. The daily dose of amphotericin B should be between 0.5 to 0.7 mg per kg intravenously. Frequent determinations of serum creatinine and electrolytes are needed to monitor for toxicity. One tries to reach the cumulative dose of 1 gm, which may take as long as a month in such patients. The treatment of amphotericin B has to be interrupted occasionally, and then restarted, as the renal function improves off treatment. Concurrently, the patient receives fluconazole, 400 mg a day, which will become a maintenance therapy after the above course of amphotericin B is completed. The maintenance dose of fluconazole is between 200 and 400 mg a day. Very few relapses occur with fluconazole. This is definitely a major advance in antifungal therapy.

Toxoplasma encephalitis is difficult to treat. There is an induction phase of treatment lasting four to six weeks, followed by the lifelong maintenance phase. The main drug is pyrimethamine, given 200 mg during the first day and 75 mg daily during the induction phase, if tolerated. In the maintenance phase, this drug is given at a lower dose of 25 mg a day. Since pyrimethamine is myelosuppressive, the antidote, leucovorin, is given at 10-20 mg a day. Frequent determinations of the complete blood cell count are needed in order to avoid the toxicity. The induction phase of treatment requires a high dose of sulfonamide also, which has traditionally been reserved for sulfadiazine, in four daily administrations of two grams. In case of allergy, sulfadiazine can be replaced with clindamycin, 900 mg every eight hours intravenously or 450 mg orally every six hours, or clarithromycin at 0.5 to 1.0 gm twice daily. In the maintenance phase of treatment, the sul-

fadiazine dose is reduced to 2 grams twice a day and the clindamycin dose is at 450 mg orally four times a day. The treatment is life-long. The most frequent reason for the relapse of cerebral toxoplasmosis is interrupted treatment. Such relapses require a rehospitalization and re-induction treatment. Therefore, the patient and his/her caregivers, including insurance carriers, must be made aware of the need for strict compliance.

Treatment against disseminated *Mycobacterium avium* complex (MAC) infection is only palliative. This is usually one of the last opportunistic infections. Clarithromycin seems to be the best drug at 0.5 gm twice a day, indefinitely. Ethambutol at 1600 to 2400 mg a day is the best companion drug. Clarithromycin is an erythromycin-related macrolide which found a unique role in the treatment of disseminated MAC infection, enabling some patients to lead active lives while on this treatment for one to two years. Other useful drugs are amikacin at 10 mg/kg IV for 10-21 days, and a fluoroquinolone, orally, at the high dose: ofloxacin 400 mg bid, or ciprofloxacin 750 mg bid, given for varying periods, to control the febrile state.

Cytomegalovirus (CMV) retinitis represents an indication for antiviral treatment. Most clinicians use ganciclovir first. This drug is given in an induction phase, at 5 mg per kg every 12 hours intravenously for the first two weeks, followed by 5 mg per kg once daily, lifelong. The latter part of the treatment is referred to as maintenance. Since March, 1995, maintenance ganciclovir may be given orally, 1,000 mg three times daily. Experimental intravitreal implants of this drug show promise. This modality is applicable to patients who experience significant loss of vision and/or toxicity while receiving the drug parentally. A high intraocular concentration of ganciclovir can be achieved with the implant. Also, longer sight preservation lasting up to eight months was noted. The main toxicity of intravenous or oral ganciclovir is hematologic. Laboratory monitoring with complete blood counts is essential, at least at two week intervals.

An alternative drug for the treatment of CMV

retinitis is foscarnet. This drug has less bone marrow toxicity, but is hard to administer because of significant renal toxicity and electrolyte abnormalities, hypomagnesemia and hypokalemia. Laboratory monitoring of blood chemistries should be done at least weekly. The drug also has significant gastrointestinal toxicity, nausea and vomiting. Foscarnet has an antiretroviral effect also, and patients who were maintained on this drug survived somewhat longer (on average, two months) than those maintained on ganciclovir. One should bear in mind here that CMV retinitis is one of the terminal infections and that patients rarely survive for longer than 12 months. In addition to the limited success in terms of sight preservation and the predictable progress of this disease, the above treatments are very costly, amounting to more than \$20,000 per anum.

PROGNOSIS

The physician is frequently asked by the patient "How long will I live?" The answer is based on survival statistics: when the CD4 count falls below 50, 50 percent of patients die within the first, 80 to 85 percent within the second, and 96 percent within the third year.

Symptomatic patients seem to be benefit more from antiviral therapy than do asymptomatic ones. It is nowadays accepted that AZT prolongs life by about 500 days. Monotherapy with ddI or ddC, compared to AZT, contributes to a shorter survival benefit. Stavudine, already commercially available, has an unknown potential as to life expectancy.

PEDIATRIC AIDS

The population of HIV-infected infants, children, and adolescent consists of several distinct epidemiologic groups. A cohort of infected children and adolescents acquired their infection via the receipt of blood or clotting factors, prior to the routine testing of such. A second group became infected via sexual activity, either via abuse, or early sexual activity. Currently, most attention is being placed upon those infants infected at birth. Vertical transmission of HIV from mother to infant can

occur in utero, intrapartum, or postpartum (via breastfeeding). Current evidence points toward intrapartum timing of infection for most affected infants. Risks for intrapartum infection may include high viral titer in the mother (such as seen with recent maternal acquisition of HIV infection, or late-stage AIDS), or viral strain characteristics.

The diagnosis of HIV infection in the newborn is complicated by the presence of passively acquired antibody. Testing involves viral culture, polymerase chain reaction, p24 antigen assay, and standard ELISA and Western blot serologies (which become more useful as the infant ages). The clinical staging of pediatric HIV infection has recently been revised. The current designations are: N, not symptomatic; A, mildly symptomatic; B, moderately symptomatic; and C, severely symptomatic. Other descriptions include: E, exposed to HIV but diagnosis not established; and SR, seroreversion from passively-acquired antibody-positivity to clear-cut seronegativity without symptoms. The CD4 count is not as useful in the infant as it is in the older infected patient, since baseline values are higher in infancy than in childhood or adulthood.

Manifestations of HIV infection in children include nonspecific entities such as "failure to thrive," recurrent bacterial infections, or developmental delay. Lymphoid interstitial pneumonitis (LIP) may mimic infectious pneumonia. Cardiac dysfunction, hepatic disease, renal disease, and a subacute encephalopathy can also be seen. Opportunistic infections of all varieties described above can also be seen in the HIV-infected child.

Prophylactic therapies include the use of TMP-SMX for prevention of *Pneumocystis* pneumonia. A complicated table is used to determine if an infant or young child is a candidate for such, based upon age-appropriate CD4 counts. Recent opinions have emerged that all perinatally-exposed infants be placed on *Pneumocystis* prophylaxis until their serostatus is clearly defined. Intravenous immune globulin (IVIG) has been proposed as a prophylactic measure against recurrent bacterial infections.

It is not clear whether IVIG yields a cost-effective benefit beyond the anti-bacterial properties of TMP-SMX. Antiretroviral therapy for infants and children continues to evolve, with recent data casting doubt on the role of AZT monotherapy.

It is estimated that 7,000 HIV-infected women give birth in the United States each year, resulting in 1,000 to 2,000 new cases of pediatric HIV infection. Antimicrobial cleansing of the birth canal, and cesarean section have been advocated as possible means of preventing transmission. A significant reduction in vertical transmission was achieved through the use of AZT (zidovudine) during the latter portion of pregnancy, intravenously during labor, and postnatally to the infant. The reduction in transmission rate (eight percent vs. 25 percent in the control group) has led to the adoption of this protocol for all HIV-infected pregnant women. It has also raised questions regarding the need for mandatory screening of pregnant women. It is recommended that HIV-infected mothers not breast-feed their infants, to prevent the small but real possibility of HIV transmission by this mode.

Because of the latency of HIV infection, it is likely that many patients diagnosed with HIV infection in their 20s were actually infected during adolescence. Thus, the topic of pediatric HIV infection must also acknowledge that adolescent sexual behavior and injecting drug use contribute a significant proportion of adult AIDS cases. Although AIDS education/prevention is a "politically-correct" cause, on a practical level it usually becomes mired in the tar-pit of personal, family, religious, school board, legal, political, and commercial interests.

PREVENTION

Since we do not have an efficient vaccine, education in avoiding exposure to HIV is of greatest importance. Worldwide, sexual contact is the most important means of transmission of HIV. Barrier controls, such as condoms, are recommended. Partner selection and avoidance of multiple sexual partners are of utmost importance. Health educators have worked out

strategies for this preventive approach. A significant reduction in vertical transmission through the use of AZT in pregnant patients is described in the above section.

Efforts to produce a vaccine have not been successful against HIV. This virus is notoriously mutagenic. This leads to many antigenic variants occurring over time even in the same patient. It was thought that a vaccine containing the surface antigen such as gp120 and gp40 may be effective. However, the antigens proved to be unstable. HIV strains for vaccine are produced in cell culture. When used as immunogens, the resulting neutralizing antibody affects the source virus, but not HIV strains freshly isolated from patients.

Another approach, currently attractive and therefore being explored, is to immunize the already infected individuals. Namely, the infected patient reacts immunologically to HIV, but the immunity is incapable of containing the infection. If immunity could be enhanced, possibly by vaccination, the struggle between HIV and the immune response could be turned to the benefit of the patient. □

ACKNOWLEDGMENT

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GENERAL REFERENCES

1. Medical Knowledge Self-Assessment Program X. American College of Physicians, Philadelphia, PA, 1994.
2. Mandell G L, Bennett JE, Dolin R. Principles and Practice of Infectious Diseases, Fourth Edition. Churchill Livingstone, Inc., Chapters 99 – 106, pp. 1164-1294, 1995.
3. Glatt AE. (Editor) Infectious Disease Clinics of North America. Management of Infection of HIV Disease. Vol. 8, No. 2. W. B. Saunders Co., Philadelphia, Pennsylvania, U.S.A., June 1994.
4. Sanford J P, Sande J P, Gilbert DN, Gerberding J L. Guide to HIV/AIDS Therapy. Antimicrobial Therapy, Inc., Dallas, Texas 75206 U.S.A., 1994 (July 1994 – July 1995).
5. World Health Organization. Interim proposal for a WHO staging system for HIV infection and diseases. Weekly Epidemiologic Record; 65: 221-224, 1990.
6. Bartlett, JG. The Johns Hopkins Hospital Guide to Medical Care of Patients with HIV Infection, Fourth Edition, Williams and Wilkins, 1994.

Editorials

AIDS: WHERE DO WE STAND?

In 1990, a comprehensive summary of the clinical manifestations and therapy of patients infected with the human immunodeficiency virus (HIV) was published in *The Journal*. Looking back, there have been few, if any, major conceptual breakthroughs since that time. The epidemic may have already peaked in some populations, yet continues to expand in others. At least to some extent AIDS — like tuberculosis — has become in the United States a “disease of the disadvantaged.” And, as a corollary, the public near-hysteria that prevailed during the early years now gives way to near-apathy.

What, since 1990, has changed about our clinical approach? Perhaps the major change has been growing uncertainty about the optimum time to prescribe antiretroviral therapy. A short while ago, most clinicians advised beginning Zidovudine (AZT) when the CD-4 lymphocyte count fell below 500 per cmm, irrespective of the patient’s symptoms. We now know that the virus develops some resistance to AZT within six to 12 months (and possibly much sooner), thereby diminishing the drug’s effectiveness. The short-term studies that prompted the initial enthusiasm for AZT have been supplanted by long-term followups that make us somewhat less confident. As a result, some knowledgeable clinicians now prefer withholding any antiretroviral therapy until patients become symptomatic. On the other hand, the new ability to quantitate the magnitude of viremia (that is, the number of viral particles present per milliliter of blood) has brought a new perspective on the relentless nature of this disease. Rather than become quiescent after initial infection (as generally happens, for instance, with herpes virus infections), the virus seems to be constantly multiplying,

and in so doing, destroying host immunity. Therefore, many leading investigators believe that we should strive toward initiating effective therapy as soon as the disease is diagnosed. In the future, however, such therapy will almost surely entail the use of combinations of drugs. A useful strategy might resemble that commonly used in chemotherapy: an intense, multi-drug induction regimen, followed by a less intense maintenance regimen. Optimum treatment is likely to become increasingly sophisticated and costly.

Another trend since 1990 has been widespread use of prophylactic drugs to prevent opportunistic infections by those who can afford them. Back in 1990, isolation of *Mycobacterium avium* from blood cultures was considered a marker of impending death. Now, especially since the introduction of clarithromycin, productive life can be sustained for at least several years in some cases despite *avium* bacteremia. Furthermore, infections by *M. avium* can be prevented, at least in part, by prophylactic therapy with rifabutin. It is possible to prevent other infections; for example, frequent fluconazole prevents cryptococcal disease. And, of course, prophylaxis against *Pneumocystis carinii* pneumonia for patients with CD4 counts below 200 per cmm has become so routine as to be justifiable as a standard of care. Yet for all the blessings of such prophylaxis, it is highly likely that we will eventually pay the price. Drug-resistant pathogens are almost certain to emerge, and, unfortunately, we have few ways to monitor some of the pathogens for the emergence of drug resistance.

A fourth trend has been the appearance of a large measure of public apathy. AIDS is no longer “news” at least to the extent that it once was, and its visibility has decreased. At the

time of this writing, a major concern is that Federal Ryan White legislation might even be cancelled, which would be an immense disaster for many of the disadvantaged persons afflicted by this virus. Most physicians, on the other hand, seem to increasingly accept HIV infection as purely a disease process that must be treated appropriately, despite their own small but definite risk. And, looking back since 1990, we should take at least a measure of pride in the medical profession's response. We have dealt with this plague at multiple levels and

with a minimum of hysteria. As dramatized by recent books and movies about still-new viral menaces from Africa, plagues have a way of bringing out the best and the worst in people. We believe that the medical profession, including in no small measure organized medicine, met the challenge of AIDS head-on and continues to be involved, demonstrating once more that we are indeed a profession concerned about the public welfare over and above our own.

—CSB

Letters to the Editor

To the Editor:

I hope you like the following article and I hope that the readership likes it as well.

GROWING DOWN AFTER GROWING UP—A NOTE FROM ONE OLD GEEZER TO ANOTHER

Have you started to trip over minor obstructions on the floor such as your throw rugs at home? Have you noticed that you no longer like to walk up steep flights of stairs? Do you find it difficult to bend over to retrieve something you dropped on the floor? Do you no longer walk as erect as you did when you were 35 years old? Do you sometimes walk around in public with your mouth hanging open? Also as you walk, do you shuffle your feet along the walkway? (In some quarters, this is called "schlepping.")

Also, have you begun to lose certain skills in your hands? Can you still tie up your shoelaces with the speed and dexterity of a 35-year-old? Whenever you find yourself in a chair, do you need the strength of your arms (or what's left of

it) to boost yourself to get up? While sitting in church with your wife and listening to a boring sermon, did she tell you that, when you lapsed off into sleep, first your eyelids fell closed, next your head fell forward, and then your upper body slumped forward before she briskly awakened you?

What the devil is going on??

Maybe you have forgotten or were never told.

Aeons ago, when you were an infant, the first thing you ever learned was how to open your eyes and keep them open. The next thing was how to hold your head up and keep your mouth closed (at about six weeks). (Were there times in later life when you should have kept your mouth shut and did not?) Next you learned how to use the great muscles along your back so you could sit up unaided (at about six months). Next was how to contract and operate the extensor muscles in your legs so that you could stand and later walk (about 1 year).

So am I going backwards? Am I losing it?

John P. Gallagher, M. D.

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SCMA NEWSLETTER

A PUBLICATION OF THE SOUTH CAROLINA MEDICAL ASSOCIATION

Joy Drennen, Editor
798-6207, in Columbia

Contributions welcomed
1-800-327-1021, outside Columbia

September, 1995

MEDICARE UPDATE

By now you should have received the September, 1995 *Medicare Advisory*. Since the *Medicare Advisory* contains important information for you and your staff, you should read it carefully each month. Included in the September, 1995 *Medicare Advisory* is information on low cost claims data entry software, claims status inquiry software, the Medicare anti-fraud unit, and much more.

Unprocessable Claims Will Reject October 1, 1995: The Health Care Financing Administration has issued instructions to all Medicare carriers on how to handle claims with incomplete or invalid information. These instructions are effective for assigned claims processed on and after October 1, 1995 and unassigned claims processed on and after January 1, 1996.

When Medicare receives a claim with incomplete or invalid information that is essential for processing, the claim will be systematically rejected as unprocessable. If the incomplete or invalid information only affects specific line items(s), Medicare will split the claim. The portion of the claim that was involved will be processed for rejection while the remaining line items will be processed separately. However, if information required in items 1-13 is incorrect or invalid, the entire claim will reject. You must resubmit the entire claim or line item that rejected with the invalid or missing information corrected.

Medicare will discuss unprocessable claims at the six regional HCFA-1500 Claim Completion Workshops in September. Please call the Medicare Part B Service Cen-

ter at (803) 788-5568 with questions about topics or space availability.

End Stage Renal Disease Facilities Approved for Ambulance Transport: Effective September 15, 1995, Medicare will only cover medically necessary ambulance transport to the approved end stage renal disease dialysis facilities. The following renal dialysis centers meet the criteria for an approved destination of Medicare ambulance services for non-skilled nursing facility patients: MUSC ESRD, Richland Memorial Hospital ESRD, Hampton General Hospital Dialysis Center, Community Dialysis Services of Bamberg, Community Dialysis Services of Hilton Head and West Columbia Dialysis. Ambulance transport of non-skilled nursing facility patients to an ESRD facility not listed above is not a covered service.

New modifiers: The following new modifiers for waiver of liabilities and foot care are effective for claims with dates of service on and after October 1, 1995:

- GA: Waiver of liability statement on file
- Q1: Certifies evidence of mycosis of the toenail which causes marked limitation of ambulation
- Q7: One Class A Finding
- Q8: Two Class B Findings
- Q9: One Class B and two Class C Findings



MEDICAID UPDATE

ICD-9 Updates: Effective with dates of service on or after October 1, 1995, the Department of Health and Human Services (DHHS) will accept the new 1995 ICD-9 diagnosis codes. Either the old 1994 or the new 1995 ICD-9 diagnosis codes may be billed during the grace period from October 1, 1995, through December 31, 1995. Effective with dates of service on or after January 1, 1996, only the 1995 ICD-9 diagnosis codes will be accepted.

Phone System: The Department of Physician Services will permanently be using the automated telephone system in an effort to better serve physician offices. When calling (803-253-6134), there are five options from which to choose:

- program manager, with a Voice Mail option,
- verification of recipient eligibility,
- verification of check amount,
- information regarding a sterilization claim, or
- the receptionist.

To reach your assigned program manager directly, it will be important that you are familiar with the correct spelling of your program manager's last name. Please refer to Section 307 of the Physician's Provider Manual for program manager assignments. Also, the receptionist can be reached at any time by dialing "0" once you have entered the automated system.

Edit Code 256: A computer problem has been identified with the processing of Medicare/Medicaid crossover claims. Edit code 256, missing Medicare amount, has been assigned to claims where Medicare has not made a payment, usually because the amount was applied to the Medicare deductible. To correct this edit, please enter "00" into the "Medicare Paid" field on the Edit Correction Form (ECF) and resubmit it to the return address on the ECF. The problem is being researched and corrective action is being made for the future processing of Medicare/Medicaid crossover claims. Medicare apologizes for any confusion or problems this has caused your office. ☐

"COUNTRY DOCTOR OF THE YEAR" AWARD

Nominations are now being accepted for an award honoring the nation's quintessential country doctor. The "Country Doctor of the Year" Award is bestowed on the rural practitioner who best exemplifies the spirit, skill and dedication of America's country doctors.

The Country Doctor of the Year will receive a personalized bronze plaque depicting the award's signature logo – a country doctor making his rounds on a horse and buggy. In addition, the honoree will be provided with an interim physician for one week, at no charge, who will cover the Country Doctor of the Year's patients while he or she takes a well-deserved rest.

The nominated physician must practice in a community of 20,000 people or less, have a record of at least three years of continuous service in the community, provide a high quality of care, and show extraordinary dedication to his or her patients.

Nomination forms may be ordered by calling Staff Care, toll-free, at (800) 685-2272.

SCMA ENTERS JOINT HEALTH CARE VENTURE

The SCMA and National Health Services, Inc. (NHS), a subsidiary of Pioneer Financial Services, Inc., have agreed to form a joint venture health care company. The two organizations will begin developing a business and marketing plan as soon as the final agreement is signed. Providers currently enrolled in PCN will have the opportunity to participate in this joint venture.

The new company will offer a variety of health plans including an HMO, with the goals of providing a broad range of health insurance products at competitive premiums and fair and reasonable reimbursement to providers. It will also involve SC physicians in utilization and management decisions and provide quality medical care. It will put the interest of the patient first by giving the physician, not the insurance company, the right to decide what constitutes the best medical care for the individual patient.

For additional information, contact Bill Mahon at SCMA Headquarters at 798-6207, ext. 224, in Columbia, or 1-800-327-1021, ext. 224, statewide.

PHYSICIANS CARE NETWORK UPDATE

The Physicians Care Network (PCN) is in the process of signing a contract with Benefits Administrators and Korn Industries to be their managed care network, effective September 1, 1995.

Korn Industries, with 705 employees, is located in Sumter; Tuomey Hospital in Sumter has agreed to join PCN effective September 1.

SCMA ANNUAL MEETING APRIL 25-28, 1996 *Omni Hotel, Charleston, SC*

*House of Delegates Meetings
Specialty Society Meetings
Continuing Medical Education
Exhibits
And much more*

MARK YOUR CALENDARS NOW

CARE LINE: 1-800-868-0404

Helping South Carolina's Women & Children

The SC Department of Health & Environmental Control, Bureau of Maternal and Child Health's CARE LINE established in 1989 is recognized by the US Department of Health and Human Services as one of six model maternal and child health hotlines in the nation.

The CARE LINE provides assistance to women of childbearing age and their families in accessing the health services they need and information to health care professionals with questions concerning the services provided in your community and surrounding communities. Specifically, the CARE LINE is trained to provide information about the following:

- prenatal care
- infant & child health care
- breastfeeding
- family planning and birth control
- well baby check-ups
- immunizations
- services for children with special needs
- Medicaid
- WIC Supplemental Nutrition Program
- women's health care (PAP smears)
- other related services offered by local health departments

For more information, call CARE LINE 1-800-868-0404.

CONFERENCES/WORKSHOPS

The Fifth Annual Conference of the SC Medical Management Association (SCMMA) will be held Thursday, October 23 and Friday, October 13 at Embassy Suites in Columbia. The conference will include a variety of top flight seminar leaders covering topics such as financial, personnel, risk and compliance management. Speakers will also cover topical issues such as managed care, information technology and integrated delivery systems. SCMMA is the professional association of medical managers service physicians' offices across the state. It has chapters in Columbia, Lexington, Pickens, Oconee, Greenville and Spartanburg and is the only medical management association affiliated with the SCMA. *For further information on the conference, contact Mary Mills Safko at (803) 791-2045.*

Winthrop University, Rock Hill, SC, and the American College of Medical Practice Executives are co-sponsoring the Management Education and Development series, a comprehensive course of study targeted to health care professionals and physicians which covers much of the material found in MBA and MHA programs. Twelve courses are presented over a 14-month period avoiding vacation months, one course per month, delivered on a Friday afternoon and Saturday morning. Starting dates: October 20-21, 1995. *For complete course descriptions, schedules and registration fees, call Ruth Dawson, Division of Graduate and Continuing Studies, (803) 323-2303.*

HIV CLINICAL TUTORIALS

The SC AIDS Training Network has announced plans for three clinical tutorials for physicians, physician assistants and nurse practitioners. The events planned are:

1. Primary Care Management of HIV Disease – Adults/Adolescents, Columbia, SC
2. Management of Pediatric HIV, Charleston, SC
3. Management of Pediatric HIV, Columbia, SC

Each tutorial will last one full day and include hands-on clinical training. There will be no charge for these tutorials; however, a refundable deposit of \$50 will be requested to reserve a slot. Each tutorial will be limited to four participants. Dates will be set once interested trainees have been identified.

For information, call Susan L. Fulmer, MPH, MS, SC AIDS Training Network, in Columbia at (803) 777-4788. □

CAPSULES

The SC Chapter of the American Academy of Pediatrics, at its recent meeting in Asheville, honored three distinguished South Carolinians.

The Honorable James G. Mattos, former member of the House of Representatives from Greenville/Pickens Counties was named Child Advocate of the Year for his contributions to the health and well-being of SC's children and his achievements on behalf of these children.

John W. Rheney, Jr., MD, was presented the 1995 Career Achievement Award for his superior accomplishments in the field of medicine. Dr. Rheney is DHEC's District Medical Director for Edisto and Lower Savannah Districts.

The President's Award was presented to *William B. Pittard, III, MD*, for his outstanding service to the Chapter, its activities and the children of the state. Dr. Pittard is currently Professor of Pediatrics, Vice Chairman of the Department of Pediatrics, and Director of Newborn Services at MUSC. □

"DOCTOR OF THE DAY"

Please remember to sign up for "Doctor of the Day" at the State House. The General Assembly is in session Tuesday through Thursday. The session begins on Tuesday, January 9, 1996, and continues through June 6, 1996. *Call the SCMA office at 1-800-327-1021 and schedule your date with Barbara Garvin, extension 230.*

On the Cover:

CHARLES ARDEN MOBLEY, M. D., 1888-1973 PRESIDENT, SCMA 1932

Charles Mobley was born in Rock Hill on March 31, 1888. He received his early education in Rock Hill and attended the University of Tennessee. He earned his M. D. degree from the Medical College of the State of South Carolina in 1910, the seventh in his family to achieve this.

Dr. Mobley practiced briefly in Van Wyck in Lancaster County before moving back to his hometown and limiting his practice to Urology.

In 1919, Mobley moved to Orangeburg where he would spend the rest of his life. He founded the Orangeburg Hospital, with 25 beds, and was its chief surgeon until his retirement in 1948. He also established a "training school" for nurses. Many of its graduates reported that they never saw an abscessed stitch while there. In the late 1920s Dr. Mobley is said to have performed a "miracle surgical feat." A two-year-old child had been run over by a combine, almost completely severing one leg and a toe. Mobley wired the bone together, connected the arteries with small rubber tubes, which were removed after four days, reconnected the nerves and sewed the muscles together by using kangaroo tendon. He took a few stitches in the severed toe and, circulation having been reestablished throughout the entire limb, the toe

mended on its own. Dr. Mobley attributed his success in the operation to emphasis of sterile conditions. Dr. Mobley at one time reported that he had performed more than 10,000 operations in his hospital without a single infection. Most of these were before the days of the "wonder drugs."¹

Dr. Mobley was a member of the founders group and a fellow of the American College of Surgeons and of the American Board of Surgery. In his President's address to the SCMA, looking back on the history of the profession and forward to the challenges he said:

We have a right to be proud, but, in our acknowledgement of the glorious past, let us not forget the present tasks, but do our part to make effective the fight of organized medicine against the great foe of mankind—disease—and make our contribution so effective that, in the end, there shall be available to all the people of the earth the best and finest services that the science of medicine affords.

Dr. Mobley died on September 14, 1973.

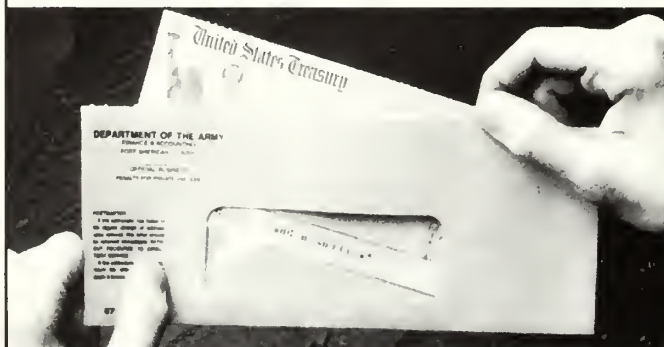
Betty Newsom
The Waring Historical Library

REFERENCE

1. Rock Hill *Evening Herald*, July 31, 1963.

PHYSICIAN RESIDENT ALERT: IF YOU COULD USE OVER \$25,000 A YEAR— ANSWER THIS AD.

The U.S. Army's Financial Assistance Program (FAP) is offering a subsidy of over \$25,000 a year for training in certain medical specialties.



Here's how it breaks down - an annual grant, plus a monthly stipend and reimbursement of approved educational expenses.

You will be part of a unique health care team where you will find many opportunities to continue your medical education, work at state-of-the-art facilities, and receive outstanding benefits.

So, if you are a physician resident who could use over \$25,000 a year, contact an Army Medical Counselor immediately.

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ANNUAL EDUCATION SYMPOSIUM OF THE
NORTH CAROLINA AND SOUTH CAROLINA
MEDICAL DIRECTORS ASSOCIATION

*For Physicians Who Practice in
Long Term Settings*

Saturday, October 14, 1995, 8:00 am-5:00 pm
Wyndham Garden Hotel, Charlotte, NC

The program will feature

- ❖ *Prevention and Management of Falls*
- ❖ *Management of Dementia-Related Behavioral Problems*
- ❖ *Polypharmacy in the Long Term Care Setting*
- ❖ *Ethical Issues in Long Term Care*
- ❖ *Appropriate Use of Rehabilitative Technology*
- ❖ *Problem Solving for the Medical Director*

Registration Material to Follow
For More Information Contact:

NC: Margaret A. Noel, MD (704) 274-6182
SC: Brad Whitney, MD (803) 457-3838



Alliance Page

SCMAA LEGISLATIVE AFFAIRS 1995-1996

The SCMA Alliance Legislative Affairs Committee has identified three goals as outlined by the AMA Alliance for the year. "Three areas to make an impact...

That give each of us a choice of how to pursue our own areas of interest and use our own talents.

The first area is **EDUCATION and COMMUNICATION...**

The key to success in the legislative arena is education...
and communicating this information to members.

But this priority is two-fold. Education and communication also applies to legislators and to those who shape opinions in our communities. They need to be educated on medicine's point of view...And to understand how their decisions will ultimately affect patients.

Our second focus area is **ACTION...**

Because our ability to respond quickly and effectively to legislative alerts on both the state and federal levels is crucial in meeting medicine's legislative goals.

The third priority outlined by the Legislative Affairs Committee is **TEAMWORK...**

Teamwork with the medical society on both the county and state levels is critical to the medical alliance's success in legislative activity..."

The Legislative Affairs Committee has planned a Legislative Workshop to be held at

The Capital City Club

Wednesday, September 20, 1995 10:00 a.m.

Speakers:

Ms. Barbara Moxon, Chairman

S.C. Advocate for Women on Boards and Commissions

Ms. Betsy Wolff, Executive Director, The Alliance for South Carolina's Children

Mr. Stephen Williams, SCMA Senior Vice President and General Counsel

Ms. Jan McKellar, SCMA, Director, Health Policy Affairs

Stephanie Evans, (Mrs. John P.) Chairman, Legislative Affairs

Arney Love, (Mrs. J. Daniel, Jr.) Co-Chairman, Legislative Affairs

If you're too busy to come to our
"Achieving Economic Freedom" seminar,
you'll probably be working late.
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Statistics indicate that only 8 percent of the doctors in the United States can retire at age 65 and maintain the present lifestyle. Join Mercer for a complimentary educational seminar and discover why health care professionals made Mercer the nation's largest fee-only financial, practice management and investment advisor. The services offered by Mercer have become so well accepted that to date twelve state Medical and Dental Associations have endorsed us to their membership. Forget working late and focus on **"Achieving Economic Freedom."**



MERCER GLOBAL ADVISORS

Tuesday, November 28
COLUMBIA, SC

Wednesday, November 29
CHARLESTON, SC

Thursday, November 30
GREENVILLE, SC

This is a COMPLIMENTARY, two hour seminar. TO REGISTER please call (800) 335-8800

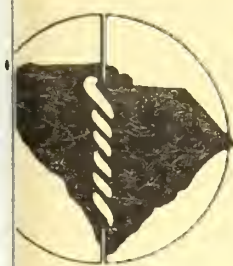
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ERRATUM

In the February, 1995 issue of *The Journal*, the following names were omitted from the list of members of the SCHS/SCMA Joint Committee on Futile Care and DRN Orders which appeared on page 56:

Pat Claypoole, Clinton
Charles R. Duncan, Jr., M. D., Greenville
Gwen Eddleman, Rock Hill
N. David List, M. D., Columbia
Charles Petit, M. D., Columbia
Kenneth Whittemore, Ph. D., Charleston

The Journal Guest Editor and staff regret this error.



Continuing Medical Education

Fourth Quarter
1995
Calendar

James L. Haynes, M. D., Chairman

Published by the SCMA Committee on Continuing Medical Education
Post Office Box 11188, Columbia, SC 29211

Note: CME activities in neighboring states are listed when space permits.

OCTOBER

Sunday-Friday **October 2-6, 1995**
Columbia, SC, Richland Memorial Hospital CCTR
4th Floor Classroom
Primary Training in Hyperbaric Medicine
SPONSOR: USC School of Medicine
DESCRIPTION: A comprehensive introduction to the
role of hyperbaric oxygen therapy in modern medical
practice.
TYPE OF AUDIENCE: Physicians, therapists, technolo-
gists, and nurses involved in hyperbaric oxygen therapy.
CONTACT: Susan Pearson, (803) 434-4211;
FAX: 434-4288
FACULTY: Dick Clarke, Robert L. Bartlett, MD
CME CREDITS: 40 Hours, AMA Category 1

Wednesday **October 4, 1995**
Columbia, SC, James F. Byrnes Center for Geriatric
Medicine, Education and Research
Search Conference
SPONSOR: Byrnes Center
TYPE OF AUDIENCE: Staff - physicians, residents,
medical students, nurses, EKGs
CONTACT: Lunch provided. Contact JoAnn Watts by
3:00 pm on the Monday before, (803) 734-0812
FACULTY: Germaine Odenheimer, MD
CME CREDITS: 1 HOUR, AMA CATEGORY 1

Thursday **October 7, 1995**
Columbia, SC, Richland Memorial Hospital CCTR
4th Floor Classroom
Annual Vascular Symposium
SPONSOR: USC School of Medicine
DESCRIPTION: Annual update on vascular surgery.
TYPE OF AUDIENCE: Vascular surgeons
CONTACT: Susan Pearson, (803) 434-4211;
FAX: 434-4288
FACULTY: Daniel S. Rush, MD
CME CREDITS: 3-4 Hours, AMA Category 1

Sunday-Wednesday **October 8-11, 1995**
Hilton Head Island, SC, The Hilton Resort
Hot Topics in Pediatrics
SPONSOR: SC Academy of Family Physicians
CONTACT: Sally George, (410) 955-0807
CME CREDITS: 18 AAFP Prescribed Hours

Sunday-Wednesday **October 8-11, 1995**
Sea Island, GA
Pediatric Critical Care
SPONSOR: Medical College of Georgia School of
Medicine
CONTACT: Katrinka Akesson, (706) 721-3967
CME CREDITS: 20 Hours, AMA Category 1

Wednesday **October 11, 1995**
Columbia, SC, James F. Byrnes Center for Geriatric
Medicine, Education and Research
Grand Rounds - Infectious Diseases
SPONSOR: Byrnes Center
TYPE OF AUDIENCE: Staff - physicians, residents,
medical students, nurses, EKGs
CONTACT: Lunch provided. Contact JoAnn Watts by
3:00 pm the Monday before, (803) 734-0812
FACULTY: Charles S. Bryan, MD
CME CREDIT: 1 Hour, AMA Category 1

Thursday-Friday **October 12-13, 1995**
North Georgia Mountains
Autumn Primary Care
SPONSOR: Medical College of Georgia School of
Medicine
CONTACT: Katrinka Akesson, (706) 721-3967
CME CREDITS: 12 Hours, AMA Category 1

Friday **October 13, 1995**
Columbia, SC, SC State Museum
Trends in Psychosocial Care of the Oncology
Patient & Family
SPONSOR: USC School of Medicine
DESCRIPTION: To develop and expand the knowledge

and skills of psychosocial staff caring for cancer patients and their families and provide a forum for networking.

TYPE OF AUDIENCE: Psychiatrists, psychologists, social workers, counselors, nurses, chaplains, and other professionals who work with oncology patients.

CONTACT: Susan Pearson, (803) 434-4211;

FAX: 434-4288

PROGRAM FEE: \$75 for physicians

FACULTY: Lisa Bryant, MD

CME CREDITS: 6.5 Hours, AMA Category 1

Friday-Sunday **October 13-15, 1995**

Atlanta, GA

Musculoskeletal Impairment & Disability Evaluation

SPONSOR: Southern Medical Association

CONTACT: 1-800-423-4992

Saturday **October 14, 1995**

Charlotte, NC, Wyndham Garden Hotel

Annual Educational Symposium of the North Carolina & South Carolina Medical Directors Association

SPONSOR: North Carolina & South Carolina Medical Directors Association and Bowman Gray School of Medicine

DESCRIPTION: Program will feature prevention and management of falls, management of dementia-related behavioral problems, polypharmacy in the long term care setting, ethical issues in long term care, appropriate use of rehabilitative technology and problem solving for the medical director.

CONTACT: Brad Whitney, MD, (803) 457-3838 in SC; Margaret A. Noel, MD (704) 274-6182 in NC

Sunday-Monday **October 15-16, 1995**

Black Mountain, NC, Blue Ridge Assembly

Empowering Teachers of Family Medicine Maternity Care

SPONSOR: USC School of Medicine

DESCRIPTION: To provide family medicine educators with requisite attitudes and working skills to use in a family-centered approach to birthing in their clinical care, teaching, and role modeling of maternity care.

TYPE OF AUDIENCE: Family practice educators in North and South Carolina who practice and teach maternity care.

CONTACT: Susan Pearson, (803) 434-4211;

FAX: 434-4288

PROGRAM FEE: \$75 for physicians

FACULTY: Elizabeth G. Baxley, MD

CME CREDITS: 6.5 Hours, AMA Category 1

Thursday **October 19, 1995**

Florence, SC, The Heritage Restaurant

Tools for Change - Hospital-Physician Integration

SPONSOR: SC Academy of Family Physicians

CONTACT: Doris Clevenger, (803) 796-3080

CME CREDITS: 4.5 AAFP Prescribed Hours

Friday-Sunday

October 20-22, 1995

Williamsburg, VA

Cancer Update

SPONSOR: Southern Medical Association

CONTACT: 1-800-423-4992

Wednesday

October 25, 1995

Columbia, SC, Crafts-Farrow State Hospital

Clinico-Pathological Conference

SPONSOR: Crafts-Farrow State Hospital and SC State Hospital

DESCRIPTION: Review the pathogenesis of diseases which include risk factors, etiology and anatomical changes in the human body for specific disease entities

TYPE OF AUDIENCE: Medical staff - Crafts-Farrow State Hospital and SC State Hospital

CONTACT: Fe' A. Cardona, MD, MPH, (803) 734-6536

PROGRAM FEE: None

FACULTY: Faculty members, Department of Pathology, USC School of Medicine, and Richland Memorial Hospital

CME CREDITS: 1 Hour, AMA Category 1

Wednesday

October 25, 1995

Columbia, SC, James F. Byrnes Center for Geriatric Medicine, Education and Research

Journal Club

SPONSOR: Byrnes Center

TYPE OF AUDIENCE: Staff - physicians, residents, medical students, nurses, EKGs

CONTACT: Lunch provided. Contact JoAnn Watts by 3:00 pm on the Monday before, (803) 734-0812

FACULTY: John Egbert, MD

CME CREDITS: 1 Hour, AMA Category 1

Friday

October 27, 1995

Columbia, SC, William S. Hall Psychiatric Institute Forum

New Directions in Brain Disorders Research: Developments and Implications

SPONSOR: Crafts-Farrow State Hospital and SC State Hospital

DESCRIPTION: A presentation on new research in schizophrenia, the neuroanatomy of normal emotion and the brain chemistry of depression.

TYPE OF AUDIENCE: Various professional disciplines such as medicine, psychology, nursing, social work, and others such as family members of mentally ill and agencies serving the mentally ill.

CONTACT: Woodrow Harris, EdD, (803) 734-6826

PROGRAM FEE: \$18 professionals; \$10 family mem-

ers of the mentally ill
FACULTY: Daniel Weinberger, MD, Director of Clinical
 Brain Disorders Branch, National Institute of Mental
 Health; Mark S. George, MD, Associate Professor of
 Psychiatry, Radiology and Neurology and Head, Func-
 tional Neuroimaging Division, Medical University of
 SC
CME CREDITS: 5 Hours, AMA Category 1

NOVEMBER

Wednesday November 1, 1995
Columbia, SC, James F. Byrnes Center for Geriatric
Medicine, Education and Research

Research Conference

SPONSOR: Byrnes Center

TYPE OF AUDIENCE: Staff - physicians, residents,
 medical students, nurses, EKGs

CONTACT: Lunch provided. Contact JoAnn Watts by
 3:00 on the Monday before, (803) 734-0812

FACULTY: Germaine Odenheimer, MD

CME CREDITS: 1 Hour, AMA Category 1

Thursday November 2, 1995

Columbia, SC, Crafts-Farrow State Hospital

Update on Treatment Modalities in Psychiatry

SPONSOR: Crafts-Farrow State Hospital and SC State
 Hospital

DESCRIPTION: Update on psychotherapy of various
 major medical illnesses by eminent psychiatrists from
 all over the nation.

TYPE OF AUDIENCE: Physicians, psychiatrists, and
 other subspecialists

CONTACT: Fe' A. Cardona, MD, MPH, (803) 734-6536
PROGRAM FEE: None

FACULTY: Samuel C. Risch, MD, Professor of Psychia-
 try and Behavioral Sciences, Medical University of SC;
 Alan C. Swann, MD, Professor of Psychiatry, Universi-
 ty of Texas Medical School; Jacob E. Mintzer, MD,
 Associate Professor of Psychiatry and Behavioral Sci-
 ence, Medical University of SC and one faculty TBA
CME CREDITS: 4.5 Hours, AMA Category 1

Wednesday November 8, 1995
Columbia, SC, James F. Byrnes Center for Geriatric
Medicine, Education and Research

Grand Rounds

SPONSOR: Byrnes Center

TYPE OF AUDIENCE: Staff - physicians, residents,
 medical students, nurses, EKGs

CONTACT: Lunch provided. Contact JoAnn Watts by
 3:00 pm on the Monday before, (803) 734-0812

FACULTY: Alan Brett, MD or Nowa Omoigui, MD

CME CREDITS: 1 Hour, AMA Category 1

Friday November 17, 1995

Charleston, SC, Sheraton Inn

Ethical Issues of Managed Care

SPONSOR: Medical University of SC

DESCRIPTION: Topics will include Fundamental Ethi-
 cal Concerns Raised by Managed Care, Physician and
 Patient Autonomy and Managed Care, Managed Med-
 ical Practice, Managed Access to Managed Care and
 Managed Death and Managed Care.

TYPE OF AUDIENCE: Physicians and all other pro-
 viders of health care

CONTACT: Odessa Ussery, (803) 792-4071

PROGRAM FEE: \$125 before October 16, \$160 after

FACULTY: Guest faculty and local faculty

CME CREDITS: 6.5 Hours, AMA Category 1

Wednesday November 22, 1995

Columbia, SC, Crafts-Farrow State Hospital

Clinico-Pathological Conference

SPONSOR: Crafts-Farrow State Hospital and SC State
 Hospital

DESCRIPTION: Review the pathogenesis of diseases
 which include risk factors, etiology and anatomical
 changes in the human body for specific disease entities.

TYPE OF AUDIENCE: Medical staff - Crafts-Farrow
 State Hospital and SC State Hospital

CONTACT: Fe' A. Cardona, MD, MPH, (803) 734-6536

PROGRAM FEE: None

FACULTY: Faculty members, Department of Pathology,
 USC School of Medicine, and Richland Memorial Hos-
 pital

CME CREDITS: 1 Hour, AMA Category 1

Wednesday November 22, 1995
Columbia, SC, James F. Byrnes Center for Geriatric
Medicine, Education and Research

Journal Club

SPONSOR: Byrnes Center

TYPE OF AUDIENCE: Staff - physicians, nurses, resi-
 dents, medical students, nurses, EKGs

CONTACT: Lunch provided. Contact JoAnn Watts by
 3:00 pm on the Monday before, (803) 734-0812

FACULTY: Laura Bird, MD

CME CREDIT: 1 Hour, AMA Category 1

DECEMBER

Friday-Saturday December 1-2, 1995

Charleston, SC, Omni Hotel

Perspectives in Pain Management

SPONSOR: Medical University of SC

DESCRIPTION: This course is designed for anesthesiol-
 ogists, pain management physicians, family practice
 physicians, neurosurgeons, orthopedists, and neurologists
 who deal with acute or chronic pain management issues.

TYPE OF AUDIENCE: See description above
CONTACT: Barbara Baylor, (803) 792-1607
PROGRAM FEE: \$365 before October 23, \$395 after
FACULTY: Guest faculty and local faculty
CME CREDITS: 14 Hours, AMA Category 1

Monday-Friday **December 4-8, 1995**
Columbia, SC, Richland Memorial Hospital CCTR
6th Floor Classroom

Primary Training in Hyperbaric Medicine

SPONSOR: USC School of Medicine

DESCRIPTION: A comprehensive introduction to the role of hyperbaric oxygen therapy in modern medical practice.

TYPE OF AUDIENCE: Physicians, therapists, technologists, and nurses involved in hyperbaric oxygen therapy.

CONTACT: Susan Pearson, (803) 434-4211;

FAX: 434-4288

FACULTY: Dick Clarke, Robert L. Bartlett, MD

CME CREDITS: 40 Hours, AMA Category 1

Monday-Sunday **December 4-10, 1995**
Hilton Head Island, SC

7th International Psychology of Health, Immunity, and Disease Conference

SPONSOR: National Institute for the Clinical Application of Behavioral Medicine

DESCRIPTION: Emphasis will be hands-on, practitioner-oriented techniques for mind/body counseling and behavioral medicine.

CONTACT: David Donahue, 1-800-743-2226

CME CREDITS: Up to 44 Hours, AMA Category 1

Wednesday **December 6, 1995**
Columbia, SC, James F. Byrnes Center for Geriatric Medicine, Education and Research

Research Conference

SPONSOR: Byrnes Center

TYPE OF AUDIENCE: Staff - physicians, nurses, residents, medical students, nurses, EKGs

CONTACT: Lunch provided. Contact JoAnn Watts by 3:00 pm on the Monday before, (803) 734-0812

FACULTY: Germaine Odenheimer, MD

CME CREDIT: 1 Hour, AMA Category 1

Friday-Sunday **December 8-10, 1995**
Miami, FL

8th Annual Regional Burn Seminar

SPONSOR: Southern Medical Association

CONTACT: 1-800-423-4992

Saturday **December 9, 1995**
Columbia, SC, USC School of Medicine VA Campus

3rd Annual Protecting Your Medical Practice

SPONSOR: USC School of Medicine

DESCRIPTION: To enhance prescribing skills, prevention, diagnosis and treatment of alcohol and other patient drug issues and answer legal and ethical questions.

TYPE OF AUDIENCE: Area physicians

CONTACT: Susan Pearson, (803) 434-4211;

FAX: 434-4288

PROGRAM FEE: \$75 for physicians

FACULTY: N. Peter Johnson, PhD

CME CREDITS: 8 Hours, AMA Category 1

Wednesday **December 13, 1995**
Columbia, SC, James F. Byrnes Center for Geriatric Medicine, Education and Research

Grand Rounds

SPONSOR: Byrnes Center

TYPE OF AUDIENCE: Staff - physicians, nurses, residents, medical students, nurses, EKGs

CONTACT: Lunch provided. Contact JoAnn Watts by 3:00 pm on the Monday before, (803) 734-0812

FACULTY: Germaine Odenheimer, MD

CME CREDIT: 1 Hour, AMA Category 1

Friday **December 15, 1995**
Columbia, SC, Crafts-Farrow State Hospital

Drug Resistant Tuberculosis

SPONSOR: Crafts-Farrow State Hospital and SC State Hospital

DESCRIPTION: Definition, epidemiology, consequences to patient and others and management of drug resistant tuberculosis.

TYPE OF AUDIENCE: Medical staff - Crafts-Farrow State Hospital and SC State Hospital

CONTACT: Fe' A. Cardona, MD, MPH, (803) 734-6536

PROGRAM FEE: None

FACULTY: Consolacion C. Mandanas, MD, MPH

CME CREDITS: 1 Hour, AMA Category 1

Wednesday **December 27, 1995**
Columbia, SC, Crafts-Farrow State Hospital
Clinico-Pathological Conference

SPONSOR: Crafts-Farrow State Hospital and SC State Hospital

DESCRIPTION: Review the pathogenesis of diseases which include risk factors, etiology and anatomical changes in the human body for specific disease entities.

TYPE OF AUDIENCE: Medical staff - Crafts-Farrow State Hospital and SC State Hospital

CONTACT: Fe' A. Cardona, MD, MPH, (803) 734-6536

PROGRAM FEE: None

FACULTY: Faculty members, Department of Pathology, USC School of Medicine, and Richland Memorial Hospital

CME CREDITS: 1 Hour, AMA Category 1



SOUTH CAROLINA

Medical Group Management Association

Founded 1978

OFFICERS FOR 1995

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BRINGING A VAST NETWORK OF VALUABLE RESOURCE TO YOU

State...

State organizations are a vital resource to medical group administrators by providing education programs, newsletters, networking opportunities and many other services. These organizations provide important information concerning your state and the local issues affecting your group. They also offer assistance in dealing with state and local legislative and legal issues as well as keeping you informed about competition, third-party payers and activities of various medical professional organizations. The state organization gives you an opportunity to meet with your colleagues on a personal and regular basis. State organizations are legally independent from the national Medical Group Management Association and are governed by their own bylaws and elected leadership. Each state organization is represented at both the MGMA regional (Section) and national levels through the MGMA Council of Presidents. The state organizations represent a very important "grass roots" and local level of Association involvement.

Regional...

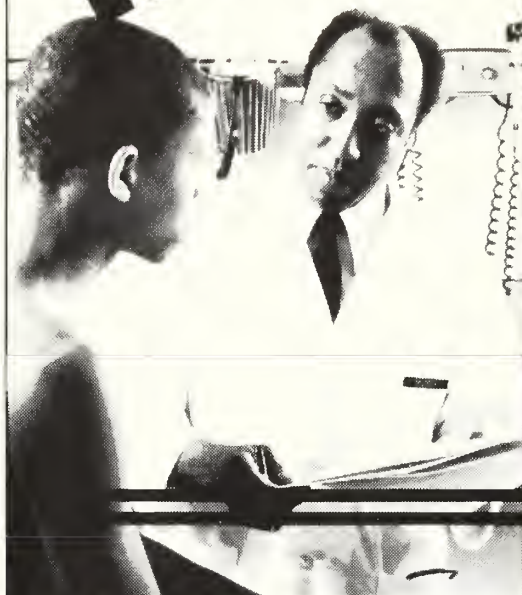
National MGMA is divided into four Sections (Eastern, Midwest, Southern and Western) and are integral to MGMA's structure and functioning. Each is represented on MGMA's Board of Directors. Each provides a vital linkage in the flow of information and ideas from the state and metropolitan organizations to the national level. Each Section presents an annual spring conference to provide you an additional educational opportunity that complements those offered at the national and state levels.

National...

MGMA was founded in 1926 and today is dedicated to improving the delivery of health care through group practice. In 1994, we reached 15,332 individual members from over 6,112 member group representing more than 121,934 physicians in all specialties and sizes of groups. We offer a vast array of educational opportunities, professional development, advocacy activities, networking, as well as research and information resources.

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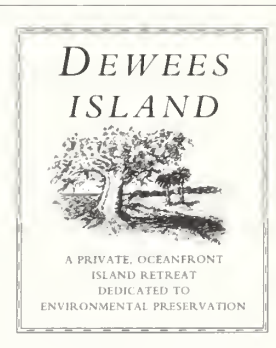
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Gray Matter

*"Matters of Interest
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Physicians."*

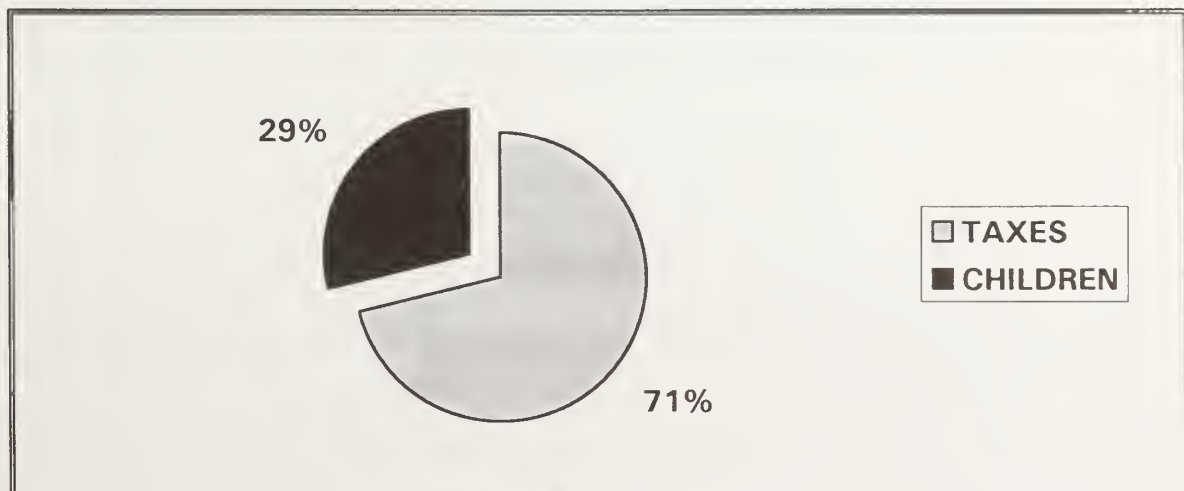
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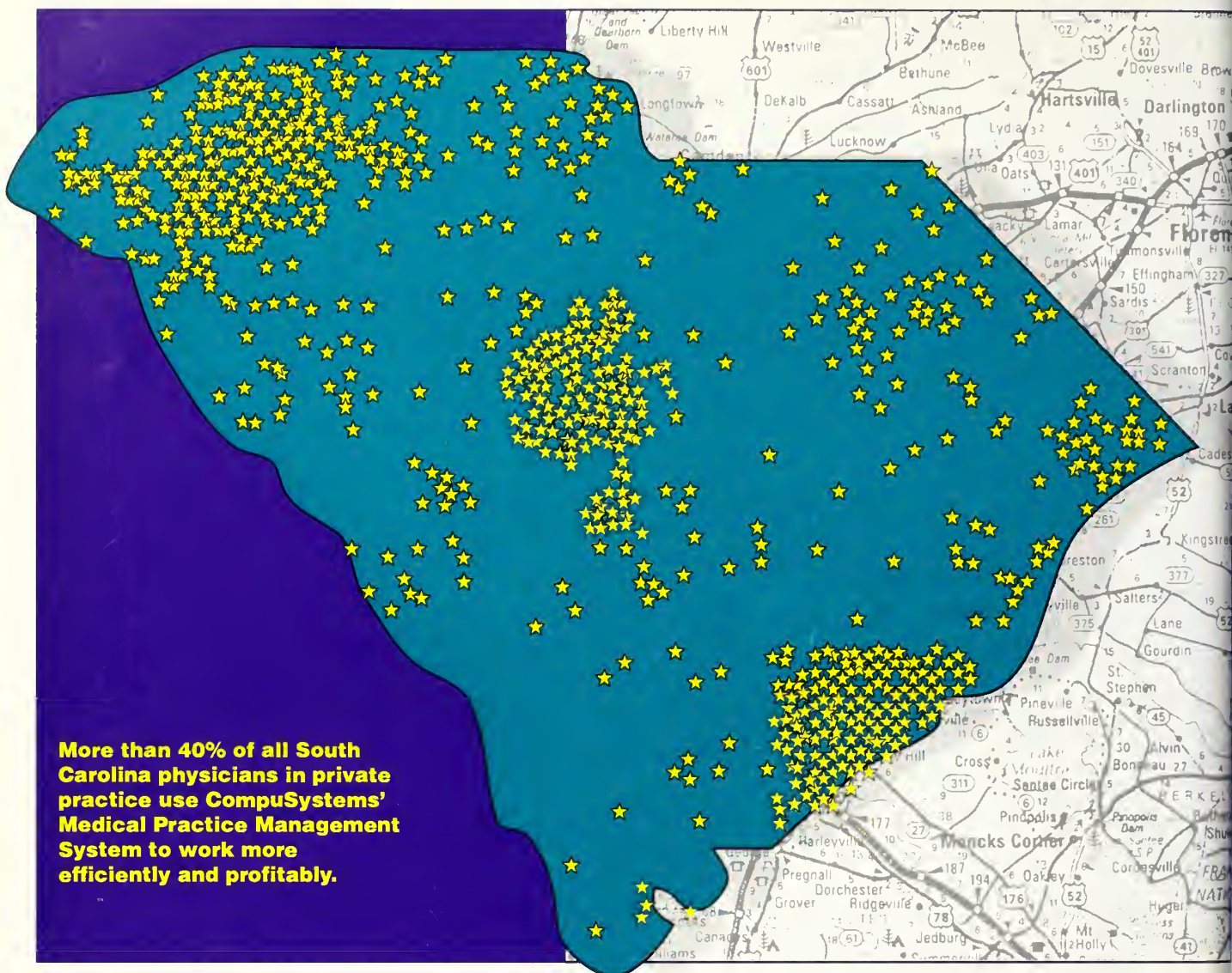
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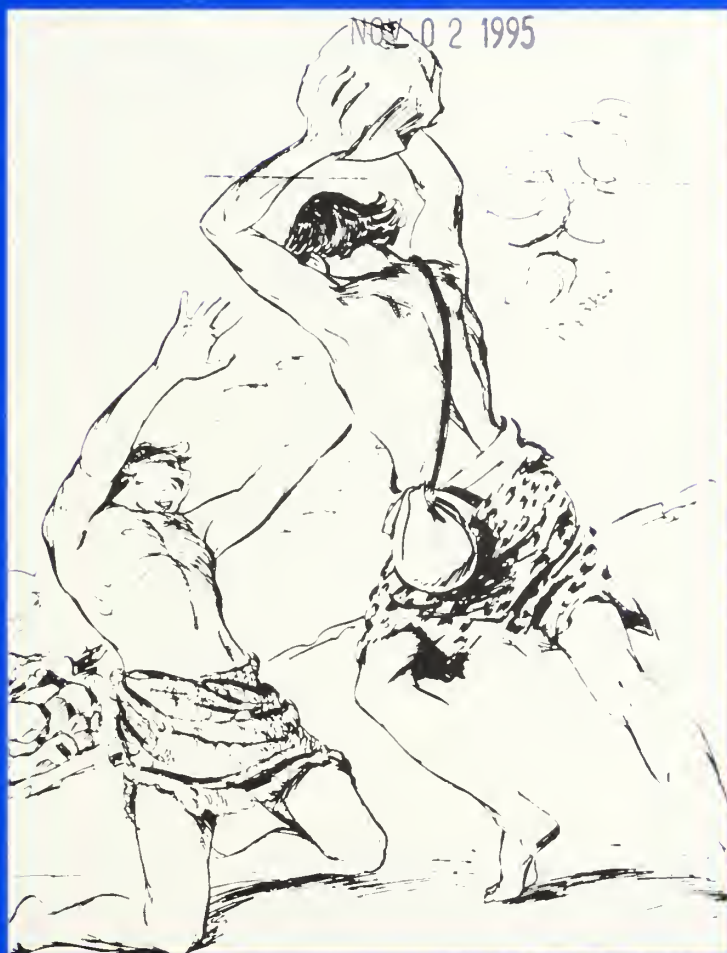
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SPECIAL ISSUE: FAMILY VIOLENCE

GUEST EDITOR: BENJAMIN E. NICHOLSON, M. D.

THE JOURNAL OF FAMILY VIOLENCE

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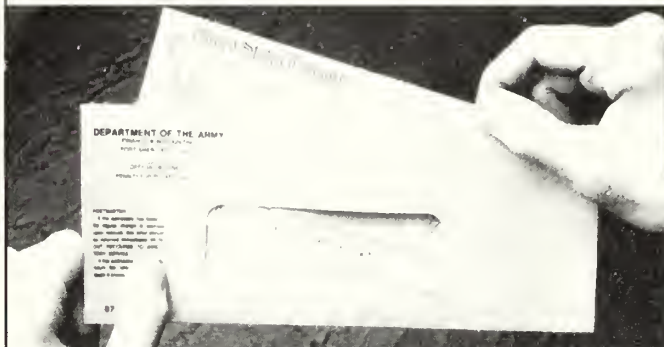
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President's Page

THE WEB OF FAMILY VIOLENCE

Family Violence is defined as the use of coercion or force by one family member with the intent to inflict injury—emotional, financial, or physical—upon another family member. The victims may be children, parents, grandparents, male or female. The abusers may come from all economic, ethical, racial or religious groups and may be women, men or adolescents.

Typically, patterns of abuse are learned by people who grow up in dysfunctional families and who may have suffered some type of abuse themselves. Frustration, stress, alcohol or drug abuse, financial problems and, we now suspect, television violence all may exacerbate the tendency towards violence. Other risk factors seem to be single parent families and families who do not have close relationships with schools, churches, or neighbors. And one recent study has found that if a person is likely to use violence, the loss of employment seems to increase this tendency more than almost any other single factor.

It is evident, therefore, both from the literature and from our own practices that family violence involves all generations and tends to perpetuate itself. This web of violence can and does spread from the family to girlfriends, boyfriends and playmates. It can trap people in relationships from which they find it almost impossible to break free. The abused wife is afraid to leave home because of her children, or because of financial or social obstacles. The elderly are dependent on those who care for them and feel they have nowhere to turn for help. And most helpless of all are the children who don't understand what is happening to them when they are physically or emotionally abused by those they love.

Since we, as physicians, are likely to be the first outsiders to see victims of abuse, we are in a crucial position to help them, and we certainly need to be better informed about how to do this. With this special issue of *The Journal* and the SCMA and alliance's Campaign For Violence-Free Families, we hope that we all can begin to help victims break through this web.

Benjamin E. Nicholson, M. D.
President

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SPECIAL ISSUE: FAMILY VIOLENCE

INTRODUCTION

BENJAMIN E. NICHOLSON, M. D.*

This issue of *The Journal* is devoted to the theme of family violence. The South Carolina Medical Association and the alliance, realizing that there has never been a coordinated state effort to combat family violence, has established the South Carolina Coalition For Violence-Free Families. This coalition includes 30 public and private agencies which are concerned with various aspects of this serious problem. Our plan is to create a reference book specifically for South Carolina which can be used as a resource for physicians and other health care workers when they are faced with cases of family violence. It will list specific resources available to them in each county and, we hope, educate them on how better to recognize and treat family violence.

In this issue we have collected articles by several concerned writers who have special experience or knowledge about this subject.

Dr. Gail Bundow discusses the phases of violence and how to recognize indicators of possible abuse and suggests methods to assess the patient.

Ms. Nancy Barton presents the case history of a battered wife and the way the system failed to help her. She lists crisis lines which are avail-

able and current shelters for battered women in South Carolina.

Dr. Sami Elhassani discusses fetal abuse, neonaticide, spousal and child abuse. He recommends using a five-question abuse assessment screen during prenatal visits to improve detection rates of battering.

Dr. Susan Breeland Ryan gives a history of recorded child abuse and the types of such abuse, presents her methods of recognizing abuse, and discusses the multidisciplinary approach to child abuse.

Dr. Paul Eleazer writes a very thorough article on elder abuse, including identification, treatment and prevention of such abuse, the legal aspects of reporting abuses, and Guardian Ad Litem services.

Dr. Peter Owens gives an interesting historical perspective of domestic violence and discusses this problem from the vantage point of his own practice.

We hope that this issue of *The Journal* will help you to understand the magnitude of the problem of family violence in our society and give you some insight on how to deal with it in your practice. □

*President, SCMA, 409 Simpkins Street, Edgefield, SC 29824.

HOW'S YOUR DOMESTIC VIOLENCE I. Q.?

GAIL L. BUNDOW, M. D.*

Look at her—look again. She's not "the broken arm in room seven" or "the frequent return visitor for chronic headaches." She's a woman hoping someone will look below the surface and see the true cause of her pain and emotional turmoil. Her home is a prison...a den of suffering. And yet many physicians just put a bandaid on the superficial wounds, and send her home again. The true problem goes unrecognized (or ignored), no alternatives are explored, her well-being goes unprotected. And we call ourselves healers?

It is difficult to define clearly just how much violence has become an accepted part of our lives...in our schools, our entertainment, and in our homes. Millions of Americans are emotionally tortured, physically abused, and sometimes killed—many in their own homes, and by someone they know.

The first step in breaking the cycle of violence is in acknowledging that it exists, then we must recognize it when it presents in our offices. Domestic violence is a major health problem which occurs in every socioeconomic class, regardless of age, race, educational or religious background.

Domestic violence is defined as the intentional use of threats or actual physical force by one member against another member of a household or relationship. This involves repeatedly subjecting this person to forceful psychological, social, and physical behavior in order to coerce them without regard to their rights. Activities which are included in this spectrum of behavior include mental degradation, verbal abuse, property violence, physical attacks, forced sexual activity or threats of serious harm to self or others.

So how do I convince you that this is an epidemic which we as physicians can no

longer ignore? Maybe a few shocking statistics will catch your attention:

- United States is ranked first among industrialized nations in violent crimes
- South Carolina is ranked as the FIFTH most violent state
- 1.1 million domestic crimes against women were reported in 1991 in the United States (this is believed to be greatly under reported)
- A woman is battered every 15 seconds in the United States
- Domestic violence results in more injuries to women than muggings, sexual assaults, and motor vehicle accidents combined

This problem should be addressed by each one of us, first realizing that we must not blame the victim! Next, efforts to understand the cycle of violence will make its identification and interruption possible.

Domestic violence has three distinct phases which repeat themselves, though the length of time for each phase is different for each couple. Typically, what occurs is that the longer a couple remains in a violent relationship, the shorter the cycle becomes. Not only does the abuse happen more frequently, but it usually becomes more violent. Described below are the three phases of the cycle.

PHASES

Tension Building: During this phase, the abuse usually consists of name calling, belittling, verbal threats, and occasional pushing or slapping. The woman often can identify this time and states she can "feel tension building." She tries to make everything "smooth" at home, trying to keep him from becoming more angry. Eventually, all control is lost and the violence begins.

Acute Battering Incident (The Explosion Phase): The abuser becomes violent. The

*Laurens County Hospital, P.O. Drawer 976, Clinton, SC 29325.

violence in this phase escalates to a more severe level than in the previous phase. The abuser is often in a rage, and can seriously injure his partner. He often demonstrates his power by verbally instilling fear through threats of harm to her or the family. Beating frequently occurs, sometimes with the use of objects or weapons. Forced sexual encounters also can occur during this violent time. It is impossible to predict the severity of the violence that will occur, nor what will "set it off." The attack is often followed by shock and denial, and the seriousness of it will often be minimized. The abuser often blames his partner for having "pushed him to it."

Honeymoon Period: Following the violent episode, there is often a period of calm, during which the abuser is "his old self" with whom the woman fell in love. He realizes that he risks losing her as a result of his actions. He is loving and kind towards his partner, begs for forgiveness, and promises to never harm her again. He probably means it at the time, and she desperately wants to believe him. The woman now is in control, and may enjoy this feeling for a short time. She can use this time to get some of her needs met. If there is a chance for them to get help, this is the time period. If he is convinced that the abuse must stop, he may seek help. However, the batterer often convinces himself, as well as his partner, that he will be able to control himself in the future.

In order for the cycle to continue, both partners become convinced that the violence will not happen again. Eventually, the tension begins to build again, the "honeymoon" begins to fade, and the cycle of violence begins again.

INDICATORS

If a patient walked into your office without obvious bruises or broken bones, could you recognize indicators of possible abuse? Try looking for any of the following "red flags" in your evaluations:

1. An increase in the number of scheduled appointments, often for vague complaints

with unidentifiable causes (major workups when done—often all negative).

2. Frequently missed appointments
3. Symptoms of depression, insomnia, physical symptoms to include headache, GI complaints, chronic pelvic pain, chest pain—frequently without documented cause.
4. Self-abuse, poor self-esteem, suicide attempts.
5. Alcohol or drug abuse.
6. Describes partner as jealous and possessive, monopolizes her time, has a volatile temper.
7. Often blames herself for problems out of her control.
8. Injuries inconsistent with history given.
9. Partner who does not want to leave during exam, answers all questions, often inappropriately affectionate, tries to control health care setting.

ASSESSMENT

In order to appropriately assess a battered woman, you must always assess her in a private place away from her partner. Questioning her in front of her partner may place her in danger. Batterers frequently threaten the woman to maintain the secret of violence (thus, the reason for her choosing to deny that violence is occurring). Maintain eye contact with your patient, and approach the topic with a nonjudgmental tone, as you would in assessing for any health problems. Encourage her to confide in you, but do not badger or get frustrated. A woman will choose when to share her secret of violence, usually not until a trust has been established with the health care provider. Permit the patient to describe her situation, and if you suspect battering, review the cycle of violence with her, and educate her about its frequency, and potential problems. Reassure her that no one "deserves" to be abused, and provide referral information for community resources. Remember that you can't "rescue" her, and force her into options for which she is not prepared. Do encourage her to look at

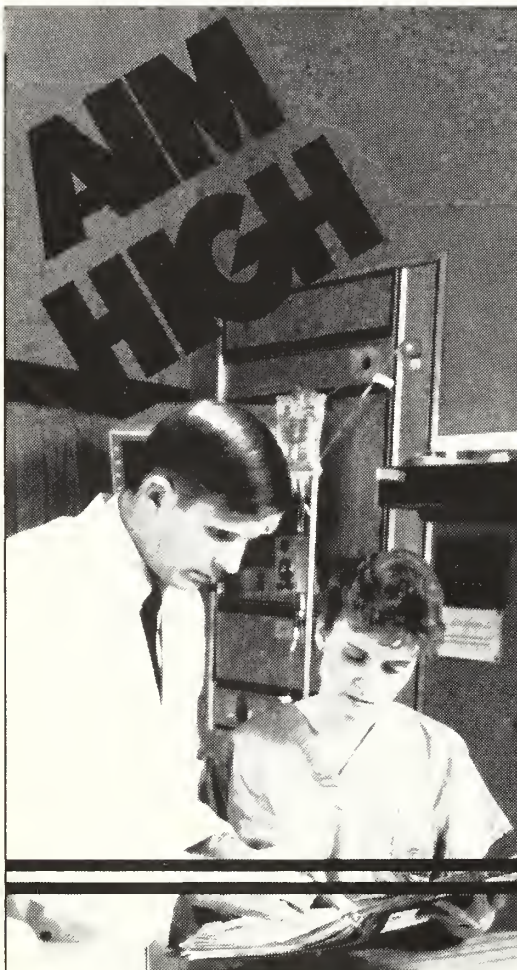
her resources and ensure her own safety.

CONCLUSION

Abuse by an intimate partner is a commonly recognized cause of illness and injury in women. It is terrifying to think that one-fourth of all American families are touched by domestic violence, but it is even more frightening to realize that we, as a medical profession, often choose NOT to treat this as a medical problem. When we know that domestic violence causes more injuries than sexual assaults, muggings, and MVAs combined—how can we continue to say that it is not a medical issue?

Physicians are on the front lines of dealing

with victims of these acts of violence, and have the ability to affect the prevalence of this form of aggression. We also have the responsibility to show compassion. Your interaction with an abused patient has an incredible effect on her. She has been through an emotionally shattering experience—she needs patience and compassion, not criticism or condescension. Finally, realize that your action, or lack of action, can have a huge impact on her life. Be aware that by NOT asking whether domestic violence is the cause of your patient's injuries or symptoms, you could be closing your eyes to the fact that this woman will most likely return home, only to be abused again...and again. □



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A CALL FOR PHYSICIANS TO HELP END THE CYCLE OF DOMESTIC VIOLENCE

NANCY BARTON, L. M. S. W.*

Choking the one you love, remaining in an abusive relationship, or committing a violent act against a wife while maintaining a successful career all seem to defy logic. The apparent irrationality of domestic violence makes it difficult for the average person on the street or the average physician in the OB/GYN clinic to understand and address this pervasive problem. Hence, we tend to minimize the choking, blame the battered woman, and excuse the abuser who looks like an upstanding, stable individual. In point of fact, love and violence do co-exist, women often return to an abusive relationship in an effort to survive economically and physically, and batterers exist in all socioeconomic, educational, racial and religious groups.

The complexity of the phenomenon of domestic violence which obscures our ability to logically understand its dynamics and course is illustrated by the violent relationship of a prominent Columbia businessman's daughter. The obstacles the young woman experienced are common to numerous battered women seeking to break free of the violence. Too ashamed to approach her family for help so early in her marriage, this woman from a privileged background contacted the Sistercare domestic violence crisis line. Overriding any impulse to talk with her parents was the knowledge of her husband's threat to kill her father whom he resented for his significant success. This woman had no reason to doubt her husband's capacity to carry out his threat based on the violence he had perpetrated against her. She explained to the crisis line counselor that when she sought guidance from her minister, she was advised to pray

harder and make every effort to be a better, forgiving wife. Feeling abandoned by her minister, she entered counseling with a family therapist only to be questioned about her responsibility for the violent relationship, her contribution to the abuse, and whether she was being a responsive wife. Such a counseling approach confirmed her feelings of guilt as an inadequate wife who caused her husband's assaultive behavior. Her increasing sense of embarrassment and shame insured she would not readily offer her personal secret and tragedy to others. She did not tell her colleagues, friends or family about her marital situation. In seeking assistance from law enforcement, the woman learned the officers would not arrest her husband unless she obtained a warrant. She was terrified of the prospect of her husband being bonded from jail and returning to their home within a matter of hours of the arrest she initiated; she did not view this as a reasonable option. When she went to the local hospital emergency room for treatment following an assault by her husband, she was relieved that no one questioned her about the cause of her injuries. Based on her past experience, this young woman had every reason to believe the medical professionals, like the others, would tacitly blame her and not offer practical assistance. She saw no escape from her abusive marriage, even if she left her husband. Could she leave him, she asked the crisis counselor, when he had threatened to hunt her down, find her wherever she settled and kill her if she ever left him?

It is believed that the most dangerous time for a battered woman is when she separates from her husband or partner. Women who leave their batterers are at a 75 percent greater risk of being killed by their abuser than those

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who stay.¹ There is no assurance an abused woman and her children can find refuge at a battered woman's shelter: nationally, 40 percent of victims of domestic violence are denied admission to battered women's shelters due to lack of available space and insufficient funding.² Over a one-year period, Sistercare, a Midlands-based domestic violence organization, turned away 667 abused women and their children following screening as a result of lack of bedspace.

Domestic violence is a prevalent phenomenon in our culture; research indicates that 28 percent of married couples report a minimum of one physical assault during their current relationship.⁵ Injuries which battered women receive are at least as serious as injuries suffered in 90 percent of violent felony crimes.³ Studies indicate 17 to 37 percent of pregnant women experience physical and sexual abuse.⁴ Children may not escape the legacy of a violent home: sons who observe violent fathers have a 1,000 percent greater chance of repeating this abuse with their own future spouses than do sons from nonviolent homes.⁵

Due to the pervasive and insidious nature of family violence, law enforcement alone cannot temper this serious problem which passes from generation to generation. An integrated community response is required to mediate violence in the home. Addressing the problem of violence against women in South Carolina will require that caregivers, service providers and other institutions assume a responsible role to include physicians, clergy, the judiciary, substance abuse and mental health counselors, prosecutors, probation officers, batterers treatment programs, children's counseling centers, battered women's programs and social services departments.

It is unrealistic to expect all physicians to be specialists in the area of domestic violence. Nonetheless, each medical doctor and staff member should adopt a protocol for identifying and addressing cases of family violence which present in their practice. Additionally, physicians can acquaint them-

selves with the battered women's program in their area to which referrals can be made for services and advocacy.

South Carolina has 14 private, nonprofit domestic violence programs serving all 46 counties throughout the state. Each organization offers a secure emergency shelter for battered women and their children as well as accompanying support. Services without advocacy prove inadequate in protecting victims of domestic violence and breaking the intergenerational cycle of domestic violence. Hence, the battered women's programs ensure legal advocacy for victims to assist them in working through the various social systems designed to respond to their needs. Individual counseling and mutual self-help support groups are a part of the shelters' service program. Community-based counseling may be offered to those battered women who are not in imminent danger and reside outside of the shelter. The scope and extent of services vary at each independent domestic violence organization.

Therapeutic services for children from violent homes have become an integral part of services at many of the South Carolina shelters. Play therapy, group counseling and therapeutic activities assist children in overcoming the destructive effect of living in a home where violence is a part of family life.

A 24-hour, seven day a week crisis line at each shelter is available to assist physicians and medical staff in making a shelter referral or obtaining information. When referring individuals for shelter admission, domestic violence programs require telephone contact and screening with the victim/survivor. While the encouragement of medical professionals may be warranted, it is important for the abused woman herself to make the decision and commitment to accept emergency shelter.

Physicians and other medical staff need to use a protocol to ascertain whether a patient is an abused woman, encourage her to seek services to address the violence in her life, and give her specific information about and a referral to the local domestic violence organi-

zation. It is not enough to simply advise the victim that she does not have to remain in the abusive relationship, does not deserve the abuse and has not caused the violence. The battered woman needs to obtain the name of the domestic violence program which can help her to learn of her options and choices concerning the relationship and to understand the laws governing criminal domestic violence. Additionally, placing literature or brochures provided by the battered women's program in confidential areas such as bathrooms or examining rooms in a doctor's office or medical clinic can be helpful. Doctors have noted that crisis cards left in waiting rooms go untouched while cards in private areas have to be replenished frequently.

Medical doctors can play a significant role

as a trusted point of contact for the abused woman through which she can obtain critical services and referrals. In this way, the victim/survivor can receive relief and the inter-generational cycle of domestic violence can begin to be stemmed. □

REFERENCES

1. Hart B; PA Coalition Against Domestic Violence, 1988.
2. Ohio Governor's Task Force on Family Violence, 1991.
3. Zorza J; "The Gender Bias Committee's Domestic Violence Study," 1989.
4. McFarlane J, Parker B, Soelsen K, Bullock L. JAMA; 267, 3176-3178, 1992. Hester A, McFarlane J, Anderson E. Amer Jour Pub Health; 77, 1337-1339, 1987.
5. Strauss M, Gelles R, Steinmetz S. Behind Closed Doors: Violence in the American Family, NY: Anchor Press, 1980.

DOMESTIC VIOLENCE PROGRAMS WITH SHELTERS IN SOUTH CAROLINA

Citizens Against Spouse Abuse	P.O. Box 912, Myrtle Beach 29578	(803) 448-6206
Citizens Opposed to Domestic Violence	P.O. Box 1775, Beaufort 29901	(803) 525-1099 1-800-868-CODA
Coalition to Assist Abused Persons	P.O. Box 1293, Aiken 29802	(803) 648-9900
Greenwood Shelter for Abused Women	P.O. Box 3410, Greenwood 29648	(803) 227-1890
My Sister's House	P.O. Box 5341, N. Charleston 29406	(803) 744-3242 1-800-273-HOPE
Pee Dee Coalition Against Domestic Assault	P.O. Box 1351, Florence 29503	(803) 669-4600
Safe Harbor	P.O. Box 174, Greenville 29602	(803) 467-1177
Safe Home	P.O. Box 1091, Laurens 29360	(803) 682-7270
Safe Homes Network	163 Union St., Spartanburg 29302	(803) 583-9803 1-800-273-5066
Sistercare	P.O. Box 1029, Columbia 29202	(803) 765-9428 1-800-637-7606
Tri-County Sisterhelp, Inc.	P.O. Box 686, Rock Hill 29731	1-800-659-0977
YWCA of the Upper Lowlands, Inc.	246 Church St., Sumter 29150	(803) 775-2763
Tri County CASA	P.O. Box 1568, Orangeburg 29115	(803) 534-2272
Worth House	P.O. Box 812, Seneca 29679	(803) 868-5800

PROTECTING WOMEN AND CHILDREN FROM PHYSICAL, SEXUAL, AND PSYCHOLOGICAL ABUSE

SAMI B. ELHASSANI, M. D.*

Nothing good ever comes of violence
—Martin Luther

"...no major disease in the history of mankind has been conquered by therapists and rehabilitation methods alone, but ultimately only through prevention."
—R. Dubos

That violence is on the rise in the United States is no longer in doubt. What is less clear is finding the best ways to prevent it. Of particular concern to physicians is that violence remains one of the leading causes of injury and death in the country, thus, it represents one of the nation's most pressing public health challenges. Among the different types of violence, domestic violence is considered one of the fastest-growing crimes in the nation. Never before have so many children and women been so vulnerable to physical, sexual, and psychological abuse as they are today. This is all remarkable since both groups are protected by federal and most states' laws.

On a local level, it is important to know that South Carolina ranks in the top 20 states in all violent crimes. Per capita, the state ranks 17th in robberies, 12th in murders, eighth in rapes, and second in aggravated assaults. Nationwide, approximately three-quarters of the rapes, murders, and aggravated assaults were committed by family members and acquaintances.

Efforts to identify the causes of domestic violence have singled out a few important factors including poverty, social isolation, and family disruption. Destroy the foundation and the house will collapse. In this simple truism

lies the problem of near disintegration of the family unit in the United States. As was shown in last year's national statistics, the smallest number of marriages since 1979 and the lowest marriage rate since 1964 were reported.¹ In fact, more couples appear to be cohabiting without legal ceremonies. In a closely related matter, the number of divorces in 1993 was over half the number of marriages that took place that year and one in four children is illegitimate. There is increasing evidence that violent crime begins in broken families and that the basis for criminal careers starts in early childhood and continues into adolescence and adulthood. Important risk factors for delinquency and violence are poor parenting, untreated conduct disorder, social stress, poverty, and school failure.²

Defenseless as they are, children are victims of brutal murder, physical, emotional and sexual abuse, neglect, and exploitations worldwide. Categorized according to the age of the victim, three specific definitions that may help in the diagnosis of different kinds of child abuse have been identified to include fetal abuse, neonaticide, and child maltreatment.

FETAL ABUSE

Fetal abuse involves a range of behaviors in pregnant women or their partners characterized by the nonaccidental performance of acts

*100 Willow Lane, Spartanburg, SC 29307.

that can be detrimental to the fetus. The well being of a significant number of fetuses depends on the mother's lifestyle. If smoking tobacco is eliminated during pregnancy, infant mortality would be reduced by 10 percent and low birth weight would decrease by 25 percent.³ Likewise, decreasing the incidence of unplanned pregnancies, decreasing the abuse of alcohol and other illicit drugs, and providing prenatal care in a comprehensive and coordinated manner could also reduce infant mortality and low birth weight. For unknown reasons, pregnancy is a particularly dangerous time for women, with more abdominal blows than facial blows reported. Abuse often begins or escalates during pregnancy. In a study of 548 Canadian pregnant women, 6.6 percent reported physical abuse during the current pregnancy and 10.9 percent before it. Of the women abused during pregnancy, 63.3 percent reported increased abuse during pregnancy, and 77.8 percent remained with the abuser.⁴ In another study of 1,014 Australian pregnant women, 29.7 percent reported a history of abuse and 5.8 percent had been abused during pregnancy.⁵ Associated fetal conditions following physical assaults during pregnancy are third trimester placental abruption resulting in fetal demise,⁶ preterm labor and chorioamnionitis.⁷

NEONATICIDE

Neonaticide is murder of the baby during the first 24 hours of age and is usually committed because the child is not wanted. According to one study conducted in England and Wales of victims of infant homicide, infants were most at risk on the first day of life accounting for 21 percent of the victims, and 13 percent of the victims were between one day and one month old.⁸ Unlike some women who kill their older children, mothers who commit neonaticide are rarely psychotic.⁹ Although rarely reported in the western world, in Japan, five cases of repeated infanticides were committed by the same mother in each case that has been documented.¹⁰ None of those mothers, however, was mentally ill.

CHILD MALTREATMENT

Child maltreatment is defined as intentional harm or a threat of harm to a child by someone acting in the role of caretaker, for even a short time. Approximately three million abused and neglected children were reported in 1992, and an estimated 2.5 percent are abused or neglected each year.¹¹ From 1,000 to 2,000 children die of maltreatment each year, more than 80 percent of them under the age of five, and about 40 percent in the first year of life.¹² Despite its prevalence, victimization of children is usually underreported and poorly represented in official statistics.¹³ Child abuse may take four different distinct forms: physical abuse, neglect, emotional abuse, and sexual abuse. Many children are victims of a combination or all of those forms. Thus, a neglected child may be physically and/or sexually abused who also may become emotionally disturbed. Moreover, the similarities between the physical evidence of child maltreatment and those of other childhood conditions are considerable. Thus, it is not surprising that confusion exists in the diagnosis of child abuse.

Of all the types of child maltreatment, physical abuse is the most recognizable clinically. Included in the physical evidence suggesting intentional injury are: multiple lesions in different stages of healing, lesions in the shape or pattern of an identifiable object (Figure 1), and trauma that seems inconsistent with the explanation given by a parent or observer (Figure 2). In addition to the clinical evidence, abnormal radiological findings in victims of child abuse are of great importance in increasing the potential for investigation and detection of injuries in single- and multiple-organ systems (Figure 3). Furthermore, the addition in the last two decades of new diagnostic tools in radiology such as bone scanning, MRI, and CAT scan greatly enhanced the ability to detect both early and late signs of child abuse.

SPOUSAL ABUSE

In 1993, according to the U. S. Department of Justice, 1,531 women in the U. S. were killed



Figure 1. Human bite injury in a six-month old infant showing teeth imprint.

by their husbands or boyfriends, up by 99 over 1992 (and 591 men were killed by their wives or girlfriends). Another four million women were beaten, abused, or raped.¹⁴ In fact, battering accounts for more emergency room visits of women than injuries from rapes, muggings, and car accidents combined.¹⁵ Fewer than 10 percent are recognized as battered women. Like abused children and adolescents, battered women too suffer from many complex psychological problems such as confusion, a state of increasing dependency, and powerlessness. In fact, women exposed to acute or prior family violence are more likely than unexposed women to have made suicidal attempts.¹⁶ Unfortunately, while reporting child abuse to the proper legal authorities is mandated by most state and federal laws, spousal abuse is often ignored and thus rarely reported.

VIOLENCE-FREE FAMILIES

Prevention of diseases is a central feature of medical care. Domestic violence is a crime and is also a preventable disease classified with AIDS, the national debt, cardiovascular disease, and cancer as most prominent public enemies. But despite an increased awareness



Figure 2. Bilateral symmetrical orbital ecchymoses secondary to blood seepage into loose tissue areas. The victim has massive subdural hemorrhage.

of the dangers of domestic violence to society, considerable confusion and controversy exist today as the most appropriate means of preventing this "silent epidemic."

One of the most effective means of lowering the incidence of family violence is through prevention strategies directed at implementing programs of early detection, removal of the victim from the violent environment, and prompt reporting to the proper legal authorities. Early assessment leads to early detection of victims of family violence. For example, incorporating a five-question Abuse Assessment Screen (Table 1) into routine social service interviews of pregnant women during prenatal visits improves detection rates of battering both before and during pregnancy, thus enabling clinicians to have a

TABLE 1
ISSUES INCLUDED IN THE FIVE-QUESTION
ABUSE ASSESSMENT SCREEN¹⁷

- 1) History of domestic violence (emotional or physical abuse).
- 2) Recent history of domestic violence (within the last year).
- 3) Physical violence during pregnancy.
- 4) Recent sexual abuse (forced sexual activities within the past year).
- 5) Fear of the partner.



Figure 3. The same infant with marked subperiosteal new bone formation along the shaft of the left femur indicating multiple old fractures. Note the marked thickness of the left femur compared with the right femur. Also, note the same subperiosteal changes in the left tibia and fibula.

greater opportunity to intervene.¹⁷

In conclusion, domestic violence must be elevated from a static state of being a "private matter" to a state of great concern to all citizens as a "a major public health hazard." It is time to reinvigorate the process.

SUMMARY

Domestic violence is a serious public health problem. The "epidemic" is becoming too obvious to hide, too widespread to deny, and too much of a health hazard to ignore. The victims are children, women, the elderly, and the society as a whole. Family members, government, educational and penal agencies, civic and medical societies, physicians, and citizens

at large are all involved in domestic violence prevention. By having a high index of suspicion, physicians are in an ideal position to prevent, assess, identify, and treat victims of domestic violence and its associated problems. □

REFERENCES

1. Wegman ME. Annual summary of vital statistics-1993. *Pediatr* 94:792-802, 1994.
2. Rivara FP, Farrington DP. Prevention of violence: Role of the Pediatrician. *Arch Pediatr Adolesc Med* 149:421-429, 1995.
3. Behrman RE, Shione PH. Neonatal risk factors. In Fanaroff AA, Martin RJ (eds): *Neonatal-Perinatal Medicine*. St. Louis, Mosby-Year Book, pp 10, 1992.
4. Stewart DE, Cecutti A. Physical abuse in pregnancy. *J Can Med Assoc* 149: 1257-63, 1993.
5. Webster J, Sweet TS, Stolz TA. Domestic violence in pregnancy. A prevalence study. *Med J Aust* 161:466-70, 1994.
6. Ribe JK, Tegatz JR, Harvey CM. Blows to the maternal abdomen causing fetal demise: Report of three cases and a review of the literature. *J Forensic Sci* 38:1092-6, 1993.
7. Berenson AB, Wieman CM, Wilkinson GS, et al. Perinatal morbidity associated with violence experienced by pregnant women. *Am J Obstet Gynecol* 170: 1760-6, 1994.
8. Marks MN, Kumar R. Infanticide in England and Wales. *Med Sci Law*. 33:329-39, 1993.
9. Resnik P. Murder of the newborn: A psychiatric review of neonaticide. *Am J Psychiatry* 126:1414-1420, 1970.
10. Funayama M, Ikeda T, Tabata N, et al. Case report: repeated neonaticides in Hokkaido. *Forensic Sci Int* 64:147-50, 1994.
11. U.S. Advisory Board on Child Abuse and Neglect, U.S. Department of Health and Human Services, *Neighbors Helping Neighbors: A New National Strategy for the Protection of Children* viii (September, 1993).
12. McClain PW, Sacks JJ, Froehike RG, Ewigman BG. Estimates of fatal child abuse and neglect, United States, 1979 through 1988. *Pediatr* 91:338-43, 1993.
13. Finkelhor D, Dzibu-Leatherman J. Children as victims of violence: a national survey. *Pediatr* 94:413-20, 1994.
14. Sassetti MR. Domestic violence. *Prim Care* 20:289-305, 1993.
15. Chez RA. A guest editorial: Physician identification of battered women. *Obstet and Gynecol Survey*. 49: 663, 1994.
16. Abbott J, Johnson R, Koziol-McLain J, Lowenstein SR. Domestic violence against women: Incidence and prevalence in an emergency department population. *JAMA* 273:1763-67, 1995.
17. Norton LB, Peipert JF, Zierler S, et al. Battering in pregnancy: An assessment of two screening methods. *Obstet Gynecol* 85:321-5, 1995.

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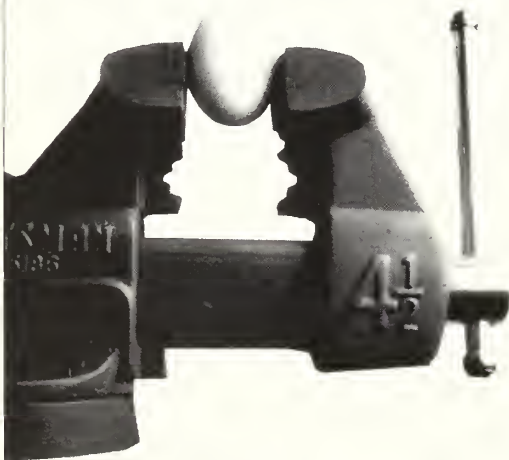
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SCMA NEWSLETTER

A PUBLICATION OF THE SOUTH CAROLINA MEDICAL ASSOCIATION
Joy Drennen, Editor
798-6207, in Columbia

Contributions welcomed
1-800-327-1021, outside Columbia

October 1995

HIGHLIGHTS OF SEPTEMBER BOARD OF TRUSTEES MEETINGS

At the Board of Trustees retreat last month, the board agreed to ask the executive committee to form an Inter-Specialty Ad Hoc Advisory Committee to work with the Department of Health and Human Services in providing physician input on the assignment of the physician dollars in the Medicaid budget, especially if block grants are decreased.

The board agreed that, at the 1996 SCMA Annual Meeting, a president's reception and inaugural ceremony would replace the president's banquet on Saturday evening. Other than the inaugural ceremony, all other activities usually held during the banquet will be conducted during Sunday morning's session of the House of Delegates.

Because of a current surplus in the MIT accounts, the board will recommend that the MIT Board decrease premiums by 12 percent for one year, then reconsider the premiums annually.

The board agreed to submit a resolution regarding Rural Health Clinics to the AMA House of Delegates because of concern regarding the increased number and cost of these clinics in SC, especially hospital-owned clinics which are not capped by a Medicare expenditure limit.

Also, the board voted to work with the SC Attorney General's office on a proposed campaign against violence in the media. □

MEDICARE UPDATE

By now you should have received the October, 1995 *Medicare Advisory* containing important information for you and your staff. Included in this *Advisory* is information on modifiers -25, -52, -54 and WF, liability insurance and Medicare secondary payer, commonly encountered action codes, and the injectable drug fee schedule.

Limiting Charge and Medicare Secondary Payer: A recent HCFA policy decision extends the limiting charge provision to nonparticipating physicians submitting unassigned claims to primary insurers when Medicare is the secondary insurer. The statute now prohibits a nonparticipating provider, who does not accept Medicare assignment, from billing or collecting amounts above the applicable limiting charge, regardless of who would be responsible for payment on unassigned claims for any date of service after December 31, 1994.

End Stage Renal Disease Facilities Approved for Ambulance Transport: Since the list of ESRD facilities approved for ambulance transport was published in the September, 1995 *Medicare Advisory*, the following renal

dialysis centers have been approved and added to the list: Anderson Dialysis Center, Columbia Dialysis Center, Greer Kidney Center and Newberry Dialysis Center.

Waiver of Liability and Modifier — GA: As reported in the September, 1995 *Medicare Advisory*, HCFA has created a new modifier, GA, that identifies you have a waiver of liability statement on file for the service you are billing. HCFA had originally intended for you to use the modifier when the claim is being filed at the beneficiary's insistence.

However, HCFA has recently revised these instructions. You should use the modifier to indicate that you have asked the beneficiary to sign a waiver of liability because you believe that the service may not be covered by Medicare based on medical necessity. Do not use this modifier for noncovered services, such as statutory exclusions, routine physicals, dentures, etc. This information will help Medicare determine who assumes financial liability for the services.

(Continued on page 2)

MEDICARE UPDATE (Continued)

Remember, if a provider renders a service to a patient which Medicare is likely to consider not medically necessary, the provider must notify the patient *in writing before rendering the service* that Medicare will probably deny the claim and that the patient will be responsible for payment. Medicare will not accept "blanket" waivers that cover all procedures that Medicare may deny. A copy of that notice signed by the patient should be attached to the Medicare claim when it is filed.

ICD-9-CM Diagnosis Code Update: The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) coding system has issued an update for claims processed on and after October 1, 1995. Medicare will accept the new codes, as well as the current ICD-9-CM codes, from October 1 through December 31, 1995. You must use the new codes for professional services billed on and after January 1, 1996 or your claim will be denied. To purchase the addendum of updated ICD-9-CM codes, as well as the code books, please contact your local book store or the AMA at 1-800-621-8335. If you are unable to locate the books through these

sources, you can call the Medicare Part B Provider Service Center for assistance.

HCFA-1500 Claims Completion Workshops Encore:

The response to the HCFA-1500 Claims Completion Workshops held in September was overwhelming. In fact, the seating capacity for three workshops was met prior to the workshops, so Medicare was unable to accommodate some providers who registered late.

Since Medicare received numerous inquiries about these workshops, Medicare has decided to hold an encore performance in Columbia, October 16, 1995 9:00 am-12:00 noon and 1:30-4:30 pm; Charleston, October 19, 1995, 9:00 am-12:00 noon; and Greenville, October 20, 1995, 9:00 am-12:00 noon. The registration fee is \$20.

Please contact the Medicare Part B Provider Service Center at (803) 788-5568 with questions about topics or space availability. A registration form is provided in the October, 1995 *Medicare Advisory*. □

MEDICAID UPDATE

Rate Changes: Effective with dates of service on or after November 1, 1995, the Department of Health and Human Services (DHHS) will increase physician rates to 74 percent of the 1995 Medicare fee schedule for codes not listed below as exclusions. In the event that 74 percent of the 1995 Medicare rate is less than the current Medicaid rate, the Medicaid rate will be reduced to 74 percent of the Medicare rate or 90 percent of the current Medicaid rate, whichever is higher.

Exceptions include (sample): all evaluation/management codes; supply and locally assigned supplemental codes; antepartum, delivery, postpartum codes; sterilizations; epidural; family planning procedures; venipuncture codes; and anesthesia unit rate.

Injection rates will be adjusted to the Average Wholesale Price (AWP) minus 10 percent plus a \$2.00 administration fee. The injection rates will also be effective with dates of service on or after November 1, 1995. A 1995 fee schedule will be forthcoming and will include all CPT and alpha code rates.

ICD-9 CM Diagnosis Code Updates: Effective with dates of service on or after October 1, 1995, the DHHS will accept the new 1995 ICD-9 diagnosis codes. Either the older 1994 or the new 1995 ICD-9 diagnosis codes

may be billed during the grace period from October 1, 1995 through December 31, 1995. Effective with dates of service on or after January 1, 1996, only the 1995 ICD-9 diagnosis codes will be accepted.

Coverage of Zithromax (Oral Suspension): Effective with dates of service on or after October 1, 1995, the DHHS will sponsor reimbursement for Zithromax that is given orally in 1 gram single-dose packets by prescription or when provided in a physician's office. The physician's office may use supplemental procedure code S9859 for each dose given and the reimbursement will be \$16 for each 1 gram single-dose packet.

Total Contact Cast Application: Effective with dates of service on or after November 1, 1995, procedure code 29445 will replace the procedure code S0102 when a total contact cast is applied.

Implantable Infusion Pumps: Implantable infusion pumps are covered when used to administer anti-spasmodic drugs intrathecally (example, baclofen) to treat chronic intractable spasticity in patients who have proven unresponsive to less invasive medical therapy as determined by the following criteria:

(Continued on page 3)

MEDICAID UPDATE (Continued)

- a. As indicated by at least a six-week trial, the patient cannot be maintained on non-invasive methods of spasm control, and
- b. Prior to pump implantation, the patient must have responded favorably to a trial intrathecal dose of anti-spasmodic drug.

Procedure

<u>Code</u>	<u>Description</u>	<u>Rate</u>
G0026	Fecal Leukocyte Examination	\$4.65
G0027	Semen Analysis	\$9.74
89190	Nasal Smear for Eosinophils	\$4.94

New Pathology Codes: Clinical Laboratory Improvement Amendment (CLIA) Certificates are issued by the Health Care Financing Administration. There are two types of certificates under which providers may only bill certain test procedures: Certificate of Waiver or Physician Performed Microscopy Procedures (PPMP) certificates. HCFA has created three new temporary codes that will be added to the list of services under the PPMP certificate as of November 1, 1995:

A forthcoming bulletin will contain more information in reference to these new CLIA codes.

Hospice Services: Effective October 1, 1995, the DHHS will add hospice services as an additional benefit under the Medicaid State Plan. Detailed coverage and policy information has been provided in a bulletin dated September 10, 1995. ☐

PHYSICIANS CARE NETWORK UPDATE

The Physicians Care Network (PCN) has signed contracts with the following new groups effective as of the dates shown:

- Elliott Sawmilling: 9/1/95
- Food Service Supplies: 10/1/95

If you have questions or would like information regarding the PCN, please call Barbara Whittaker or Cindy Osborn at the SCMA.

DHEC DRUG CONTROL UPDATE CONTROLLED SUBSTANCES REGISTRATION CERTIFICATE

Physicians are reminded to check the expiration date on their current SC Controlled Substances Registration certificate. If the expiration date indicated is not **October 1, 1996**, the physician should contact the DHEC Bureau of Drug Control at **(803) 935-7815**. Any certificate which does not bear an October 1, 1996 expiration date expired on October 1, 1995, and failure to renew such registration by October 31, 1995 will result in a \$25 penalty, in addition to the \$100 registration fee. Further, failure to renew by December 31, 1995 will result in cancellation of the registration, which may only be renewed by payment of a \$100 penalty, in addition to the \$100 registration fee, and a showing of just cause.

Physicians are also reminded that they must notify the Bureau of Drug Control of any changes of address. Failure to notify of any such changes may result in cancellation for failure to renew, with resulting penalties, should such physician desire to renew at a later date.

CHILD HEALTH MONTH

October is recognized as Child Health Month. In 1992, the American Academy of Pediatrics established Child Health Month to focus public awareness on child health issues with an emphasis on the value of preventive health care.

This year's theme for Child Health Month is violence prevention. Violence is injuring and killing children in America at epidemic proportions. Child abuse and neglect is a leading cause of death for children age four and younger, with homicide the third leading

cause of death for children age 10 to 14 and the second leading cause of death for children over 15.

According to Francis Rushton, MD, president of the SC Chapter, AAP, "Violence is preventable and we are encouraging our colleagues and the health care community at large to promote Child Health Month with activities in their workplace, schools and communities." □

CAPSULES

Randolph D. Smoak, Jr., MD, Orangeburg, a former SCMA president and currently a member of the AMA Board of Trustees, has been appointed by the AMA to the Joint Commission on Accreditation of Healthcare Organizations. He will replace outgoing commissioner Nancy W. Dickey, MD.

Larry R. Faulkner, MD, has been named Vice President for Medical Affairs of the University of South Carolina and Dean of the School of Medicine. Dr. Faulkner has served as interim dean since March 1, 1994.

Harold W. Sanford, Jr., MD, of Union, and **Samuel E. Wood, MD**, of Walterboro, have been named as fellows of the American College of Radiology (ACR). The announcements were made during the ACR annual meeting held September 9-13, 1995, in Boston, MA.

Tommy B. Griffin, MD, Spartanburg, has won a complimentary two-night stay at the Omni Hotel at Charleston Place. His name was entered in a drawing for this prize when he returned a survey form mailed by the CME Departments of MUSC and the USC School of Medicine, in cooperation with the SCMA, to 350 recipients of CME credits at the 1995 SCMA Annual Scientific Assembly.

RESPONDING TO CHILD MALTREATMENT

SUSAN BREELAND RYAN, M. D.*

Child abuse and neglect have been around since the earliest recorded time. The form and manner of child abuse have changed somewhat, but the sad fact of child abuse persists. Historically, outright infanticide was practiced as a matter of course in selected situations, as with a firstborn female child or a deformed infant. Later, child abandonment became quite common, and it was not at all unusual to give one's children over to a "wet nurse" until the children were old enough to return and work in the fields—about three or four years old. With the Industrial Revolution, children became valuable income-producing property, and were put to work by the thousands in conditions which most adults would not tolerate today.

It was not until the late 1800s that the first case of child abuse was prosecuted in the United States. The child was a 12-year-old in New York City who had been informally adopted as a baby and was severely neglected and physically abused for years before she came to public attention. At that time, no laws existed in this country regarding child maltreatment, although there was extensive regulation of animal treatment, since animals were vital to survival and commerce. The New York Society for the Prevention of Cruelty to Animals succeeded in having the child removed from the home. Shortly thereafter, laws were passed in every state limiting the manner in which children could be handled.

The maltreatment of children has become a problem of staggering dimension in South Carolina. During 1994, well over 20,000 reports of suspected child abuse or neglect were made to the Department of Social Services (DSS). Of these, 30 percent were "founded" cases, meaning that sufficient evidence was found to substantiate the report

and that the case fell within guidelines for DSS involvement. Our state experience reflects that of the nation as a whole.

Child maltreatment can be broken down into five broad groups:

1. Physical abuse, ranging from overly-aggressive disciplinary measures to fatal assault.
2. Physical neglect, which is the intentional withholding of one or more of the necessities of life, such as food, clothing, shelter or medical care.
3. Emotional abuse, which may range from covert acts of failure to provide a supportive and nurturing environment to overt acts such as belittling the child or making specific threats against the life of the child or a loved one.
4. Sexual abuse, which is the use of a child for sexual pleasure. This may include intercourse, fondling, pornographic photography, exhibitionism, or other sexual activities.
5. Institutional abuse, which is any of the preceding forms of abuse, when it occurs in an institution, such as a daycare or chronic medical care facility.

RECOGNIZING CHILD MALTREATMENT

Surprisingly, medical personnel often are poorly trained in recognition of the physical and behavioral signs of abuse and neglect, and ill-prepared to brave the winds of the "system" once a report is made.

Physical findings which should arouse suspicion include:

- Bruising in unusual areas or patterns. The majority of accidental bruises in children are located in bony prominent portions of the body. A concentration of bruises in more protected areas, such as the buttocks, warrants careful consideration as to the origin.
- Injuries which do not fit the history.
- Repeated injuries, or a history of "clumsiness" or "easy bruising."

*Abuse Recovery Center, 1800 Colonial Drive, Columbia, SC 29202.

- Epiphyseal fractures.
- Any fracture in a child under two years old.
- Retinal hemorrhages.
- Unusual vaginal or penile discharges.
- Diagnosis of a sexually transmitted disease.
- Nonorganic failure to thrive.

Behaviors which may indicate abuse or neglect include:

- Any behavior which is at an extreme for the child's age, whether excessive passivity, fearfulness or hostility.
- Sexually aggressive behavior.
- Role reversal, with the child assuming an adult role beyond what is age-appropriate.
- A statement made by a child, or by a witness, that abuse has taken place.
- A sudden, unexplained change in a child's behavior.
- "Doctor-shopping" by parents.

For physicians, the most difficult step in recognizing child maltreatment is the ability to entertain the notion that people sometimes do not tell the truth. For the most part, we are trained and encouraged to believe what we are told. Indeed, most people seeking medical care are quite truthful, since their health or very lives depend on our having an accurate picture of what has been happening with them. In child abuse, there is often strong incentive **not** to tell the truth. It is imperative that the physician objectively compare a child's injuries to the history, taking into account:

- The child's developmental age. For instance, a history that a four-month-old walked off the front porch and broke his leg is not believable from a developmental standpoint.
- The location of the injury.
- The severity of the injury.
- The pattern or shape of the injury.
- The age of the injury. For example, an obviously fresh red-blue bruise explained as having happened two weeks ago should evoke suspicion that the history is not accurate.

Having decided that an injury is suspicious for abuse, or having suspicion of sexual abuse or neglect, the practitioner must then report his concerns. Generally, if the abuser is thought to be a parent or caregiver, the local county DSS

should receive the report. If the suspected abuser is not a parent or caregiver, the local law enforcement agency is responsible for investigation. If in doubt, the local DSS office can provide guidance in reporting.

THE MULTIDISCIPLINARY APPROACH

One of the more significant advances in management of cases of suspected child abuse in recent years has been the development of the multidisciplinary approach to investigation. Physicians and other medical providers are a vital part of the multi-disciplinary team, which includes social services, law enforcement, mental health and other agencies. Physician responsibilities include:

- Being knowledgeable about physical and behavioral indicators of abuse and neglect.
- Reporting suspected abuse or neglect to the proper social service or law enforcement agency. The South Carolina Child Protection Act requires that any physician, nurse, or other medical care provider "having reason to believe" that a child has been, or may be, abused must report his concerns.
- Assisting investigators in interpretation of medical information as it relates to the question of abuse or neglect.
- Participating in the judicial system.
- Treating injuries or illness resulting from abuse or neglect.
- Providing psychosocial support for the child and family.
- Maintaining objectivity. Rarely is it the physician's role to determine **who** is responsible for the abuse or neglect.
- Documenting physical findings, history, statements and any other pertinent information.

CONCLUSION

Significant inroads have been made toward identifying, treating and preventing the various forms of child maltreatment. It is crucial that physicians and other medical practitioners approach this problem as a serious threat to the physical and emotional well-being of South Carolina's most precious natural resource, its children. □

ELDER ABUSE

G. PAUL ELEAZER, M. D.*

"Abuse, like beauty, is in the eye of the beholder."

—J. Callahan

The South Carolina Omnibus Adult Protection Act of 1990¹ included a provision that mandates reporting of elder abuse by physicians. The penalties for failure to report include up to one year in jail and a fine of up to \$2,500.00. The mandatory reporting requirements and significant penalties for failure to report reemphasize the importance of correct identification and reporting of elder abuse.

THE HISTORICAL PERSPECTIVE

Elder abuse has been present presumably since antiquity. Records from the 19th century have shown elder abuse at that time, particularly in cases where three generations were living together. More recently, attention to elder abuse was highlighted when the United States House Select Committee On Aging brought elder abuse to the forefront in 1980-1981.² Findings of this committee included the following:

1. Four percent of community dwelling elders are abused.
2. Family members are usually the abusers.
3. Elder abuse crosses ethnic and socioeconomic barriers.

Research has shown typical characteristics of both victims and abusers. Older studies showed that victims are more likely to be female, have some degree of dementia, be dependent on a single caregiver, be socially isolated, and have difficult behaviors (paranoia, belligerence, wandering, insomnia, etc.), although more recent studies have challenged these findings.³

Characteristics of abusers have also been

defined.^{2,3} Common characteristics often include substance abuse and alcoholism and a prior history of abusive behavior. Solo caregivers are more likely to be abusive and have a heavy burden of care. Often this burden of care has been prolonged or extremely heavy. This latter fact is important for prevention since availability of community based services may help prevent elder abuse.

A number of different types of elder abuse and neglect have been described. *Physical abuse* is generally less common than other forms but is devastating to the elder. Physical abuse may involve slapping, hitting, burning, beating or sexual assault. *Physical neglect* is one of the more common forms of elder abuse and may be related at times to poor caregiver education. Physical neglect includes not providing food, water, medications or clothing. Elders also need adequate heating, cooling and assistive devices such as eye glasses, dentures, hearing aids and walking canes and denying these may constitute neglect. *Psychological abuse* may include threats, insults, harassment, harsh orders, withholding of affection, and behavior designed to increase social isolation (denying visitors, travel, attendance at church, etc.). *Material or financial abuse and exploitation* is a common problem and may pre-stage other forms of abuse. Stealing pension checks or not using funds for the support of the elder, inappropriate use of the elder's home, car or other personal property may qualify as financial abuse or exploitation.

IDENTIFYING ABUSE

Table 1 outlines some of the typical signs of abuse for each of the categories above. In

*University of South Carolina, Department of Medicine, Division of Geriatrics, P.O. Box 119, Columbia, SC 29202.

TABLE I
SIGNS OF ELDER ABUSE

I. Signs of Possible Physical Abuse	
(A) Bruises	(E) Decayed teeth
1. Multiple	(F) Broken eye glasses/hearing aids/walking canes, etc.
2. Variable color (Age)	(G) Inadequate cooling or heating
3. In the shape of as striking object	
4. On ankles and wrists	
5. Inner aspects of arms or thighs	
(B) Welts	III. Signs of Possible Psychologic Abuse
(C) Fractures/dislocations	(A) Low self-esteem
(D) Lacerations	(B) Anxiety
(E) Burns	(C) Withdrawal
(F) Overmedication	(D) Depression
(G) Genital/rectal pain or itching, bleeding	(E) Confusion
(H) Sexually transmitted diseases	(F) Mood swings
II. Signs of Possible Physical Neglect	IV. Signs of Possible Financial Abuse and Exploitation
(A) Poor hygiene	(A) Inadequate funds for medications and services
(B) Malnutrition	(B) Caregiver inappropriately concerned with costs
(C) Dehydration	(C) Unpaid bills
(D) Decubitus ulcers	(D) Inability of the caregiver to account for expenditures

addition, there may be general clues that an abusive situation exists. Significant delays in seeking medical treatment, frequent emergency department visits or frequent office visits are reasons to become suspicious. Unexplained trauma, failure to thrive, non-compliance with medications may all be markers of an abusive situation. Unusual interactions with caregivers including the patient caregiver being fearful, conflicting accounts as to a mode of injury, caregiver anger and indifference to the patient, or the caregiver denying privacy for the examination are all suggestive of an abusive situation.

The physical examination is often revealing in evaluating cases of physical abuse and physical neglect. Signs of *physical abuse* may be bruises, especially if in unusual places such as the inner aspects of the arms or thighs, or soles of the feet. Multiple bruises that are clustered and of various ages (judged by color) may also be a clue. The shape of a bruise may mimic a striking object (for example, a hair brush). Ankle and wrist bruises may be from restraints. Welts from coat hangers or belt whipping may be present if received within a matter of hours prior to hours of examination. Fractures and disloca-

tions should raise concern, especially when the history is incompatible with the injury. Unusual lacerations, burns in unusual locations or in the shape of a cigarette, genital or rectal pain, bleeding or sexually transmitted diseases may all be marks of physical abuse. Overmedication can be another sign of abuse while undermedication may indicate neglect.

Physical neglect may be intentional or unintentional. Signs of physical neglect may include poor hygiene, malnutrition, dehydration, pressure sores, decayed teeth, broken eye glasses or other adaptive equipment. Overgrown nails and unkempt hair may also be markers. The patient who presents with hypothermia in winter or hyperthermia in summer may have had neglect due to lack of appropriate heating or cooling in the home and this may be a mark of physical neglect. Sometimes caregivers try to keep a frail person at home, beyond their capability to provide care. This may fall under the promise made to "Never put momma in a nursing home." Such families are especially in need of physician support to either have services supplied in the home or to proceed with nursing home placement.

Psychological abuse may be more difficult

to identify but is suggested by low self-esteem, anxiety, withdrawal, depression, confusion and mood swings. *Material/financial abuse and exploitation* is relatively common and may be delineated through the history. Be suspicious of financial abuse when there are inadequate funds for medications, services, or when the caregiver seems inappropriately concerned with costs. Multiple unpaid bills and an inability for the caregiver to account for expenditures of the patient's pension check are clues which an office manager, social worker, or financial counselor may detect and subsequently report to the physician.

REPORTING

The Omnibus Adult Protection Act of 1990 requires physicians to report suspected abuse by telephone or in writing within 24 hours or one business day to the Long Term Care Ombudsman Program for incidents occurring in facilities and to the Adult Protective Services Program for incidents occurring in all other settings. In cases of emergency, law enforcement must also be contacted.¹ Penalties include up to one year in jail and/or a fine of up to \$2,500.00.

TREATMENT

Treatment varies depending on the nature of the abuse and availability of other resources to assist in stopping the abuse. For physical abuse, the patient's safety must be assured promptly. The physician is required to report abuse to appropriate authorities (Adult Protective Services Division of the Department of Social Services; Law Enforcement). Often patients will be temporarily placed in the acute care setting, other institutional settings, or with a different caregiver. With less serious forms of abuse, there may be less urgency and more time for other interventions. Family interventions include counseling, job training, treatment for alcohol and drug abuse, and family therapy. In cases of neglect, family education may be adequate while in other cases additional supportive services in the

home will be required to meet the needs of the elder. Community based services such as personal care aides, sitter services, meals on wheels, etc. can make a difference in a situation that is either neglectful or bordering on neglectful. The availability of community based services is important and is an area in need of expansion in South Carolina. In some cases, adequate in-home support is not available and the elder must be institutionalized. Financial or material abuse can be addressed by appointment of a Guardian Ad Litem and is often handled through the Adult Protective Services Department of the South Carolina Department of Social Services.

PREVENTION

Prevention of elder abuse includes maintenance of close social ties with relatives and friends in a support network to help when an elderly person becomes more frail. Accessing support services such as chore services, housekeeping, home delivered meals, senior recreation, adult day care, respite care and transportation assistance are all appropriate methods of preventing the caregiver burnout which contributes to abusive situations. Elders should avoid living with persons with a background of violent behavior, alcohol or drug abuse. Older persons should also be encouraged to refuse to sign any documents unless someone they trust has reviewed them. Prevention from a statewide planning perspective should include public awareness programs as well as improved caregiver support

KEY POINTS REGARDING ELDER ABUSE

- Elder abuse is relatively common but overlooked; a high index of suspicion is warranted.
- Physicians are required under penalty of law to report elder abuse.
- Treatment for and prevention of elder abuse are available.
- Report suspected abuse to your local adult protective services office, or law enforcement agency, or long term care Ombudsman's office.

through expanded community based services offered through community long term care, the Councils on Aging, DHEC, private long term care providers, and others.

FURTHER READING

A recent detailed review article by Lachs and Pillemer is an excellent resource for physicians and others interested in this subject.⁴

CONCLUSIONS

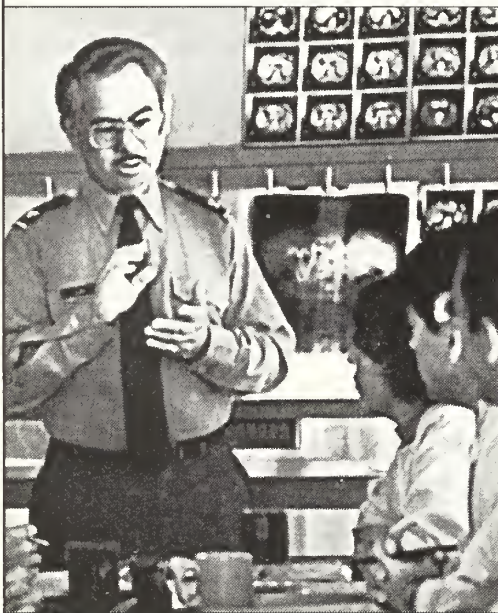
Elder abuse is a common problem and will become more common as our population ages. Physicians are required under penalty of

law to identify and report elder abuse in South Carolina. Physicians should become familiar with the symptoms and signs of elder abuse and appropriate means of reporting and helping patients and their caregivers to prevent and treat this syndrome. □

REFERENCES

1. South Carolina Omnibus Adult Protection Act. Sections 43-35-25, 43-35-30, 1990.
2. Elder Abuse and Neglect. Council on Scientific Affairs. JAMA. 257 (7): 966-971, 1987.
3. Lachs MS, Fulmer T. Recognizing elder abuse and neglect. Clinics in Geriatric Medicine. 9(3): 665-681, 1993.
4. Lachs MS, Pillemer K. Abuse and neglect of elderly persons. NEJM. 332(7): 437-443, 1995.

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DOMESTIC VIOLENCE: IMPACT ON PSYCHIATRIC MEDICINE

PETER L. OWENS, M. D.*

It is gratifying to see the SCMA devote an entire issue to the problem of family violence. As physicians, we are in a unique position to play a key role in decreasing the morbidity and mortality of this syndrome. The figures defining family violence in our country are horrifying, and most physicians are unaware of their magnitude. Approximately eight to 12 million women in the United States are at risk of being abused by their current or former partners.¹ Almost 3.5 million children between the ages of three and 17 are at risk of being abused by parents; 20 percent of all children are abused before they reach adulthood.² For the purposes of this article, I have chosen to narrow the focus to domestic violence or spousal abuse.

Over the last seven to eight years, patients who have suffered from domestic violence or who have a history of sexual or verbal abuse have been referred to me in increasing numbers. As we focus on preventive mental and medical care, these figures provide extra incentive for us as physicians to become more aware of our patients' suffering and of the role we might play in lowering costs—physical, psychological, social, and economic—resulting from such violence. This article attempts to provide an overview of the scope of domestic violence, describe psychiatric symptoms that aid in the identification of victims, and discuss interventions open to physicians.

DEFINITIONS

Domestic violence is part of a larger syndrome of family violence that also includes child abuse and elder abuse. Spouse abuse will be defined as "a pattern of coercive behavior marked by physical, emotional, sex-

ual, psychological and economic intimidation used to maintain power and control."³ A spouse is further defined as a current or former partner or anyone with whom the abused patient has or has had an intimate or romantic relationship.

EPIDEMIOLOGY

Approximately 3.8 million women are abused each year in our country. The FBI estimates a woman is abused every 18 seconds and that a female dies from domestic violence every six hours. Whereas about six percent of all murders of males are committed by a mate, between 30 and 50 percent of all murders of females are committed by their spouses. Wife beating causes more injuries in females than do motor vehicle accidents and muggings combined. The overall estimated health care cost of domestic violence is between three and five billion dollars per year.⁴

HISTORICAL PERSPECTIVE

Domestic violence has been a characteristic of many civilizations. A group of paleopathologists recently compared the number of fractures in Egyptian mummies and found that 30 to 50 percent of female mummies had fractures, while fractures were evident in only nine to 20 percent of male mummies. The most common fracture among female mummies was that of the skull.³ The similarities of the percentages in this paragraph and the one above are striking.

Most laws and statutes in the United States were adopted from English Common Law where one can find this statement: "Wife beating is permitted only for the purpose of correcting behavior deemed inappropriate by the husband." In the 1600s Pennsylvania adopted the Rule of Thumb law: "Wife beat-

*2 Jervey Road, Greenville, SC 29609.

ing is permitted with a stick no larger than the thumb, and is prohibited on Sundays and after 10:00 p.m."³ English Common Law further defined the role of women in marriage. A woman could neither own property nor sign contracts. She could not even own the wages that she might earn. She could not vote, and, as such, had no legal standing. Her legal existence was merged with that of her husband.⁵ Our socio-cultural perspective on domestic violence has its roots in this mentality.

RISK FACTORS FOR DOMESTIC VIOLENCE

Understanding the variables associated with increased risk for domestic violence may help physicians identify these patients. A recent study reviewed 52 research articles and evaluated 42 separate variables for increased risk of being abused, and the most common risk factor was having been abused as a child, or, as a child, having witnessed abuse.³ Having been sexually molested increases the risk 30 to 60 percent that the person will grow up to be an abuser or victim. Pregnancy is a common risk factor for women, as is alcoholism; female alcoholics have a 45 percent likelihood of being assaulted.⁴ In addition, substance abuse, social isolation, unemployment, and overcrowding can each increase risk.

These factors keep the abused patient locked into potentially dangerous pathologic situations. One's self-confidence and self-esteem are profoundly damaged by abuse. One's ability to adapt to and deal with conflict in interpersonal relationships is colored by these patterns. Women often persist in dangerous situations out of concern for their children, for financial reasons, and out of religious belief that they married for better or worse. They may also stay because of love. Often, they stay because of a very real sense of danger: the perpetrator threatens either to kill them or to kill their children. Women even blame themselves as the cause for abuse. One of my patients recently said, "If I hadn't burned the beans, he wouldn't have hit me."

PHYSICIAN AWARENESS

A retrospective study of 107 abuse victims in a large metropolitan hospital found that only five percent of cases were identified as abuse by physicians. In another study, emergency room physicians estimated that approximately one in 35 patients presents to the emergency room with signs, symptoms, and/or sequelae of domestic violence; yet most studies on this subject have found the incidence to be closer to one in four.⁴

Physicians refer patients for psychiatric consultation in only four percent of cases and utilize social services referral in only eight percent of identified cases of domestic violence.⁶ These figures are probably representative of the overall level of physician awareness of the extent of domestic violence. Statistics like these have led the American Medical Association to define domestic violence as a major health problem and to establish an educational program on this topic.

There is, then, a general lack of awareness as to the prevalence and seriousness of this problem. But other societal and personal attitudes on the part of the physician may affect the physician's reaction to patients suffering from domestic violence. Some think, incorrectly, that the patient brings the abuse on herself; others believe that what happens behind closed doors is the business only of the husband and wife. We are often confused and angered that the wife will not leave.

Some physicians have a prior history of personal abuse; seeing it in others opens old wounds. The more like the physician that a patient is, both culturally and socially, the less likely the physician is to ask questions. However, the number one reason physicians are reluctant to ask patients about the possibility of abuse is time. With an office full of patients waiting for us, we tend to look the other way.

CLINICAL FINDINGS AND DIAGNOSIS: PSYCHIATRIC DISORDERS

Approximately 25 percent of all female suicide attempts occur in the context of domestic

violence; 25 percent of all women using psychiatric services have been abused; and 63 percent of all female psychiatric inpatients report a history of physical abuse.⁷ I believe any patient who presents with symptoms of depression or anxiety, suicidal behavior, symptoms of post-traumatic stress disorder, sleep disturbances, and/or substance abuse should be asked about a history of domestic violence. When patients report a history of child abuse or sexual molestation, physicians should inquire about the patient's own potential to perpetrate abuse, especially child abuse.

Although adult patients will sometimes report their past problems with abuse, younger patients often do not know what is happening to them. When a child comes to our offices, he or she may not be able verbally to describe the home situation. But we may find indicators of an abusive home situation in delays in reaching developmental milestones, school refusal, separation anxiety disorders, behavioral problems with aggression, sexual promiscuity, venereal disease, and early pregnancy.⁸ Children living within the abusive home may also present with major psychiatric disorders. Recent data associate the positive symptoms of schizophrenia with childhood physical and sexual abuse.⁹

These patients may also have myriad hypochondriacal complaints. They are more prone to depression and to anxiety disorders such as post traumatic stress disorder or panic attacks, and they have a greater tendency to abuse alcohol and drugs. Sleep disturbances are also quite common.¹

In my own practice, I now ask every patient about a history of current or past trauma, both sexual and physical. There are often no overt signs, and I am more often than not surprised by positive answers and a willingness by patients to discuss these very difficult subjects. They need our support and understanding.

But such patients can be frustrating and disconcerting to the physician. Sometimes

patients' emotions are communicated indirectly because they feel we may reject them. I believe it is most important for us to provide unconditional support. We need to reframe the "victim role" and make it a "survivor role." We must be willing to support a patient who takes a long time to make a decision to leave a dysfunctional marriage and dangerous situation.

An evaluation for underlying psychiatric disorders is important, as is ruling out the potential for suicide. Referrals for psychiatric evaluation and possible psychotherapy should be recommended. It is also useful to schedule a follow-up interview to evaluate further both the seriousness of the situation and the patient's compliance to recommendations for follow up.²

In addition to psychiatric evaluations, referrals to social service agencies may be in order. Physicians should know about the existence of women's shelters in their communities as well as support groups for patients who have been abused. Table 1 provides a list of such organizations; Table 2 lists reading material physicians can recommend to patients.

SUMMARY

The 1984 Attorney General's Task Force Report on Domestic Violence attested:

Anyone who lives in a violent home experiences an essential loss. The one place on earth where they should feel safe and secure has become a place of danger...the shadow of domestic violence has fallen across their lives and they are forever changed.¹⁰

One report states that the victims of the crime of domestic violence include "not only the people who die from injuries, but the family members who daily endure the psychological, emotional and spiritual abuse and pass on the emotional scars and violent behavior to one generation after another."¹⁰ If we are to stop this cycle of violence, we as physicians must step forward and assume our personal and professional responsibilities. □

TABLE 1
ORGANIZATIONAL RESOURCES FOR
VICTIMS OF ABUSE

Resource	Telephone
SC Department of Health & Human Services Adult Protection Coordinating Council P.O. Box 8206 Columbia, SC 29202	(803) 253-6142
SC Department of Mental Health Community Support Programs 2414 Bull Street Columbia, SC 29202	(803) 734-7854
SC Department of Social Services Division of Adult Services Office of Children, Family & Adult Services P. O. Box 1520 Columbia, SC 29202-1520	(803) 734-5670
SC Office of the Governor Division on Aging 202 Arbor Lake Drive Suite 301 Columbia, SC 29223	(803) 737-7500
SC Office of the Governor Division of Ombudsman & Citizens' Service 1205 Pendleton Street Columbia, SC 29201	(803) 734-0457

TABLE 2
SUGGESTED READING

1. Gondolf EW, Fisher ER. Battered Women as Survivors: An Alternative to Treating Learned Helplessness. New York: Free Press, 1988.
2. Statman JB. The Battered Woman's Survival Guide: Breaking the Cycle. Dallas: Taylor Publishing, 1990.

REFERENCES

1. American Medical Association. Diagnostic and treatment guidelines on domestic violence. Arch Fam Med 1:39-47, 1992.
2. Butler DJ, Qualheim K, Turkal N, Wissing M. Men sexually abused in childhood: sequelae and implications for the family physician. Arch Fam Med 2:29-33, 1993.

3. Dickstein LJ. Spouse abuse and other domestic violence. Psychiatr Clin North Am 2:611-28, 1988.
4. Council on Scientific Affairs, AMA. Violence against women: relevance for medical practitioners. JAMA 267:3184-9, 1992.
5. Noel NM, Yam M. Domestic violence: the pregnant battered woman. Nurs Clin North Am 27:871-84, 1992.
6. Saunders DG, Kindy Jr P. Predictors of physicians' responses to woman abuse: the role of gender, background, and brief training. J Gen Intern Med 8:606-9, 1993.
7. Salber PR, Taliaferro E. The physician's role in identifying and managing domestic violence [video-recording]. Secaucus, NJ: Network for Continuing Medical Education, 1995.
8. Wolfe DA, Korsch B. Witnessing domestic violence during childhood and adolescence: implication for pediatric practice. Pediatrics 94:594-9, 1994.
9. Ross CA, Anderson G, Clark P. Childhood abuse and the positive symptoms of schizophrenia. Hosp Community Psychiatry 45:489-91, 1994.
10. Haack D, Sage A. The physician's role in domestic violence. Colorado Med 88:60-1, 1991.

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Editorials

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—CSB

BREAKING THE CYCLE OF VIOLENCE

Last year, one out of every 100 South Carolinians was a victim of a violent crime—rape, murder, assault or armed robbery. Because the problem of violent crime is not unique to our state, the U. S. Attorney's office has made violent crime a top priority. Often times, however, when most people think of criminals, they envision faceless strangers. Unfortunately, most of the frightening and harmful violence takes place at home, inside the family.

In 1994, the South Carolina Department of Social Services received almost 22,000 reported cases of child abuse and neglect, involving over 49,000 children. Three-quarters of the rapes, murders, and aggravated assaults were committed by family members and acquaintances.

Crimes against women are rising at a significantly faster rate than total crime. Nationally, an estimated 700,000 rapes are committed or attempted every year. Three to four million women are victims of family violence, and less than half of all violent crimes against women are reported.

To fight the rising tide of abuse and violence and to protect the rights of victims, Congress enacted the Violence Against Women Act (VAWA) as part of the 1994 Crime Bill. The Act makes it a federal offense to cross state lines to continue abuse of a fleeing spouse or partner. It also imposes tougher penalties for perpetrators of sex crimes. VAWA also authorizes a substantial new commitment of federal resources—more than \$1.6 billion during the next six years—

for police, prosecution, prevention, and victim service initiatives in cases involving violence or domestic abuse.

The 1994 Crime Bill gives victims of violent crime or sexual abuse the right to speak at the sentencing of their assailants in federal court and prohibits anyone who is under a restraining order for domestic abuse from possessing a firearm. Additionally, VAWA requires sexual offenders to pay restitution to their victims, requires states to pay for rape examinations and authorizes \$1.5 million for federal victim-witness counselors.

Security begins at home. Children must feel safe in their homes and mothers must raise their children in safety. As a society, we must constantly endeavor to improve the future of our children.

Domestic violence is a gigantic web that entraps countless generations of people. It perpetrates itself when children grow up watching one parent beating the other parent. This cycle of violence must be broken before we lose yet another generation.

Joseph Preston "Pete" Strom, Jr.
U. S. Attorney
District of South Carolina
1441 Main Street, Suite 500
Columbia, SC 29201

LET'S FOCUS ON PREVENTION, NOT TREATMENT, OF CHILD ABUSE AND NEGLECT

Many of us in the medical field are experiencing increasing frustration with the issue of child abuse and neglect. Frequently confronted with evidence or allegations of abuse, we valiantly attempt to document all physical evidence that corresponds with the complaint, and then provide it to the appropriate agency. Our practices suffer from disruption, as we labor to perform a complete and thorough evaluation, and then are called upon to testify in court. Unfortunately, the resulting interventions to which our patients are subjected too often appear to us do them more harm than good. Destruction of the family, disruption of support structures for the child, and aggravation for the health care provider all too often appear to be the results of our current approach to dealing with this difficult problem.

Our experiences in health care with child abuse are not unique. Twenty-five years ago, there were a total of 60,000 reports of suspected child maltreatment. Five years ago the number of reports increased to three million. Child abuse and neglect is a growing crisis in this country. It's a crisis that the country appears inadequately prepared to address with an appropriate response. As the U. S. Advisory Board on Child Abuse and Neglect reports, "the system that is intended to help and protect abused and neglected children does little to mitigate the nightmare. Instead, of emphasizing prevention of maltreatment, America's child protection system usually steps in when damage has already been done. Instead of easing tensions within families and bringing them closer together, the system too often exacerbates those tensions. Instead of helping children, the system tends to funnel children into a process over which they have no control and that doesn't necessarily act in their best interests."¹

Indeed, in the last 10 years there has been a growing awareness of the need to shift our

focus away from the treatment of child abuse and neglect to its prevention.^{2,3} Many professionals feel that it may be more useful and cost effective to intervene, especially in high risk situations, before the abuse occurs. Once actual child maltreatment has happened, it can be extremely difficult to rehabilitate the family involved.⁴ Health care providers are uniquely positioned to change the focus towards the provision of screening and prevention services for child abuse. No other professionals come in routine contact with the majority of our youngest citizens on a regular basis.⁵

The Center for Youth Research at the University of Hawaii sponsored a gathering of experts from around the country to discuss successful prevention programs for abuse and neglect. The most effective programs appeared to have a number of features in common. These include prevention and treatment services that:

- strengthen family and community supports and connections.
- treat parents as vital contributors to their children's growth and development.
- create opportunities for parents to feel empowered to act on their own behalf.
- respect the integrity of the family unit and serve it holistically.
- enhance parents' capabilities to foster the optimal development of their children and themselves.
- establish linkages with community support systems.
- provide settings where parents and children can gather, interact, support, and learn from each other.
- enhance coordination and integration of services needed by families.
- enhance community awareness of the importance of health parenting practices.
- provide emergency support for parents day and night when they needed help.⁶

The U. S. Advisory Board on Child Abuse and Neglect suggests several specific ways we can develop effective family support structures. Voluntary home visiting for all expectant and new parents, substance abuse treatment programs, parent education programs focusing on the healthy development of children, and respite care programs, particularly for parents with fragile or nonexistent natural support systems, are all rational methods for reducing child neglect and abuse.⁷

Diagnosis and treatment of domestic abuse have limited effectiveness. Together, we as health professionals have an obligation to work more effectively by concentrating on prevention. An emphasis on supporting families so that they can effectively provide the love and nurturing that all children require will reap extensive rewards in our quest to prevent child maltreatment.

Francis S. Rushton, Jr., M. D.
130 S. Ribaut Road
Beaufort, SC 29902

REFERENCES

1. U. S. Advisory Board on Child Abuse and Neglect: Neighbors helping Neighbors: A new National Strategy for the Protection of Children. Department of Health and Human Services, Washington, September, p.viii, 1993.
2. Dubowitz H: Pediatrician's role in preventing child maltreatment. *Pediatric Clinics of North America* 37:989-1002, 1990.
3. Garbarino J: Can we measure success in preventing child abuse? Issues in policy, programming and research. *Child Abuse and Neglect* 10:143-56, 1986.
4. Dubowitz H: Cost and effectiveness of interventions in child maltreatment, *Child Abuse and Neglect* 14:177-186, 1990.
5. U. S. Advisory Board on Child Abuse and Neglect: Neighbors helping Neighbors: A New National Strategy for the Protection of Children. Department of Health and Human Services, Washington, p.72, 1993.
6. Wilson K: Exemplary neighborhood-based programs in preparation. Institute for Families in Society, University of South Carolina, Columbia.
7. U. S. Advisory Board on Child Abuse and Neglect: A Nation's Shame: Fatal Child Abuse and Neglect in the United States. Department of Health and Human Services, Washington, p.141, April 1995.

On the Cover:

FAMILY VIOLENCE

"And Cain talked with Abel his brother: and it came to pass, when they were in the field, that Cain rose up against Abel his brother, and slew him."

—Genesis 4:8

This terse statement from the book of Genesis is the first recorded account of family violence between family members, and a prime example of sibling rivalry gone amok. Unfortunately, there was little further publicity on this subject for several millennia.

It is reasonable that in the days and years of settling and developing a new country—a period marked by individualism and self sufficiency—family violence, if it occurred and it almost certainly did, was "not talked about." Abuse thrives in the shadows of privacy and secrecy. It lives by inattention. Those who have protected themselves from being witness to it have at the same time protected the practice and have thus been a party

to it. The evolution of a social conscience along with technical advances such as x-ray for diagnosis and world wide media for distribution has brought this horror into our daily lives.

The "Stop Hurting, Start Healing" Campaign For Violence-Free Families which is being spearheaded by the South Carolina Medical Association and Alliance is designed to educate physicians and the public about the prevalence of family violence and suggest ways to prevent it. This project deserves our total support.

Betty Newsom
The Waring Historical Library



Alliance Page

1995—96 SCMAA HEALTH PROMOTIONS

The SCMAA will assist the AMAA in a national health promotion called **SAVE—Stop America's Violence Everywhere**—by focusing attention on this pervasive problem that exists in homes, schools, streets and media. Central to the program will be **SAVE Today**, held annually on the second Wednesday of October to emphasize violence prevention in communities nationwide. Medical alliances throughout South Carolina are planning awareness activities on October 11 for **SAVE Today**, as well as participating in the **SAVE** Program year-round to meet specific local needs.

Together, the SCMA and SCMAA will lead a collaborative effort to break the silence of family violence through the **SC Coalition For Violence-Free Families**. Through this campaign, the SCMAA plans to assist in the development of a reference book citing all available county-by-county services for victims of family violence. By educating ourselves and the public about the seriousness and prevalence of family violence, the SCMAA hopes to encourage victims of abuse to recognize physicians as sources of help. Consequently, efforts will be made to heighten physician awareness to the signs of family violence and abuse.

During the 1995-'96 year, the SCMAA will again support projects that emphasize adolescent health. Fifty thousand **TEEN DIRECT LINE CARDS**, listing telephone numbers of crisis prevention services, will be distributed by alliance members through community agencies, organizations, churches and schools. To assist county alliances in the development of adolescent pregnancy prevention awareness, Joy Campbell, Director of the SC Council on Adolescent Pregnancy Prevention, will inform the SCMAA membership of opportunities and available resources for community project implementation during the Fall Board Workshop.

For the second year, the SCMAA will be an active partner in the Governor's Statewide Immunization Outreach Campaign. Through local collaborations and community projects, the SCMAA will help maintain the 90 percent immunization rate that distinguished South Carolina as the national leader in protecting children from the complications of preventable childhood diseases. An April conference, "**Surviving and Thriving**," is being planned by the SCMAA, the Alliance for South Carolina's Children, the Junior League and the Institute for Families in Society to focus attention on the critical issues of children between birth and six years old.

The SCMAA continues to encourage and support additional health promotion activities of county alliances that help meet individual community needs and therefore improve our health and quality of life.

Gail L. Robinson (Mrs. Thomas L.)
Health Promotion Chairman, SCMA Alliance

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Gray Matter

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59	2,823	1,490
54	2,823	1,490
59	4,397	1,490
59	4,397	1,490
52	4,397	1,490
59	4,397	1,490
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REPORTING HIV INFECTION IN CHILDREN
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BACKFIRE: AHCPR PRACTICE GUIDELINE
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President's Page

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SCMA BOARD MEMBERSHIP

NOV 27 1995

During a meeting with the president of a specialty society, he suggested that many physicians in his society feel the South Carolina Medical Association (SCMA) is dominated by primary care physicians and that the interests of certain specialties are not considered. This has disturbed me greatly, as the SCMA is an umbrella organization which represents all specialties, no matter their size. The last thing we physicians need right now is to bicker and fight among ourselves. The House of Medicine must speak with one voice during this time of relative chaos in the medical world.

The present Board of Trustees of the SCMA is equally represented by primary care physicians and other specialists. I am a primary care physician. Your president-elect is a neurologist. We all try to leave our specialty hats outside the board room and to discuss issues from the standpoint of what is best for all of us.

SCMA board meetings are open to all members of the SCMA, and I would like to extend an invitation to any of you to attend our meetings. Several years ago we tried to improve our communications with local societies by inviting the presidents of these societies to our board meetings. Very few local presidents took advantage of this invitation, and the program was not a success. I would like to renew this invitation and extend it to the specialty society presidents as well.

In the past, membership on the board has been partly determined by geographic location, with local districts choosing their trustees who are then elected by the House of Delegates at the SCMA Annual Meeting. Generally these trustees have been nominated by their districts because they have been active in their local society and not because of their specialty. I suggest that if you want to be active in the SCMA leadership, you should first be active in your local medical societies. The statement has been made that primary care physicians control the local societies and will not elect other specialists. It would be to everyone's advantage for the leadership in each society to consider this statement. If a problem exists, hopefully the society will work to resolve it and that all specialties should be more active in their local societies.

The American Medical Association (AMA) is currently studying the issue of representation in its House of Delegates. It may well decide that we should elect our representatives in a different manner. Our board will be receptive to any suggestions which will ensure fair representation for all physicians, and it is quite possible that we may change our method of electing trustees with suggestions from the AMA and physicians in our state. However, I doubt that this could include guaranteed seats for certain specialties on our board; the number of specialty societies in the state would make the board too large to function efficiently. Any proposed changes would, of course, have to be approved by the SCMA House of Delegates.

In conclusion, I would like to reiterate the importance of being active in your local medical societies so that all of us can work together for the good of our patients and our profession.

Benjamin E. Nicholson, M. D.
President

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REPORTING HIV INFECTION IN CHILDREN: PHYSICIAN PRACTICES AND PERCEPTIONS*

PAMELA A. MEYER, M. S. P. H.**
JEFFREY L. JONES, M. D., M. P. H.
DEE C. BREEDEN, M. D., M. P. H.
CAROL Z. GARRISON, PH. D.

This statewide survey was conducted to assess physicians' HIV reporting practices and reasons for not always reporting HIV infection in children. Questionnaires were mailed to South Carolina pediatric subspecialists likely to care for HIV-infected children (N=59), and randomly selected general pediatricians, family practitioners and general practitioners (N=436). Of the 335 (68%) responding physicians, 86 percent indicated always or usually reporting HIV-infected children and 82 percent perceived primary care physicians to be responsible for reporting. Some of the 44 physicians indicating not always reporting expressed concern about confidentiality (n=10) and discrimination (n=12). HIV infection reporting is generally accepted in South Carolina, but confidentiality and discrimination concerns and physician responsibility for reporting must be addressed to further

improve HIV reporting.

INTRODUCTION

The physician's role in diagnosing and caring for children infected with human immunodeficiency virus (HIV) makes physician support and acceptance of HIV reporting necessary to achieve a high level of reporting. Acceptance of HIV reporting by South Carolina physicians was suggested by a 1989 study.¹ In that study, 79 percent of physicians surveyed indicated that HIV infection, as well as AIDS, should be reportable by name to the state health department as required by a 1986 statute.² However, that study excluded primary care pediatricians since at that time few children had been reported with either AIDS or HIV infection. In addition, reporting of HIV-infected children was not specifically addressed and attitudes concerning reporting HIV infection in children compared to adults may differ. This report highlights physicians' practices and attitudes regarding reporting HIV infection in children.

METHODS

In June 1992, the South Carolina Department

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of Health and Environmental Control (DHEC) staff distributed the first of three mailings of a confidential questionnaire to 495 licensed South Carolina physicians. The physicians surveyed included all pediatric subspecialists likely to come in contact with a child exposed to HIV and a 29 percent random sample of general pediatricians and family and general practitioners. The pediatric sub-specialists (N=59) were pediatric allergists, pulmonary sub-specialists, neonatologists, and hematologist/oncologists listed in the most recent (1992) directory published by the South Carolina Board of Medical Examiners. The primary care physicians were randomly selected from the State Medical Association's list of licensed general pediatricians (N=347), family practitioners (N=853) and general practitioners (N=289). The 436 primary care physicians surveyed included 117 general pediatricians, 243 family practitioners, and 76 general practitioners. Systematic substitutions were made for physicians from the random sample who had retired or who no longer practiced in the state (N=114). Two (three percent) pediatric subspecialists had either retired or were no longer practicing in South Carolina.

Physicians, nurses, social workers, health educators, epidemiologists and statisticians were consulted to develop the questionnaire. The questionnaire was pre-tested by physicians and modified before the first of three mailings. An introductory statement explained the study's purpose and that questions applied to children under age 13. Multiple choice questions allowed physicians to check their type of practice, who they perceived to be responsible for reporting, how routinely they report and their reasons for not always reporting HIV-infected children to DHEC. Space was provided for physicians' open-ended responses to why they did not always report.

Epi Info³ software was used to generate random numbers and to calculate sample size. The sample size for the general pediatricians, and family and general practitioners allowed

for 10 percent error with 95 percent confidence adjusted to allow for 30 percent non-response. Prevalence ratios (PR) with confidence intervals were calculated for comparisons of categorical variables and t-tests were calculated to detect differences in years of practice.

RESULTS

Physician response was 68 percent overall, and by type of practice was 73 percent for general pediatricians, 65 percent for pediatric subspecialists, 70 percent for family practitioners, and 57 percent for general practitioners. Compared to responding physicians, the 160 non-responding physicians were similar in type and number of years in practice (21 years vs. 20 years), but were more likely to have an urban practice (46 vs. 33 percent; PR=1.4; 95 percent CI 1.1, 1.7).

Most (86 percent) physicians indicated they always or usually report children who test positive for HIV (253 always, 33 usually, three sometimes, two occasionally, one rarely, five never and 38 did not answer the question). Physicians who indicated they always report compared to those who indicated they do not always report were similar in their practice type (primary care vs. subspecialist) location (urban vs. rural) and in having cared for a child with HIV infection or AIDS. However, physicians who indicated always reporting were 1.2 times (95 percent CI 1.1-1.3) more likely to be affiliated with a large hospital than physicians who indicated not always reporting (Table 1).

Table 2 summarizes the reasons for not always reporting given by the 44 physicians who indicated they do not always report. In response to the multiple choice questions they indicated concerns about discrimination (27 percent) and confidentiality (23 percent), the belief that someone else had reported the child (20 percent) or the child had been reported in another state (two percent), or the reporting process is too cumbersome (nine percent). Write-in responses were forgetting (five percent), not treating pediatric AIDS

TABLE 1.
CHARACTERISTICS OF PHYSICIANS BY THEIR RESPONSE TO HOW OFTEN
THEY REPORT CHILDREN WITH HIV INFECTION (N=297)^a

Characteristics	Always Report (N=253)	Do Not Always Report (N=44)	Prevalence Ratio	95% CI Ratio
Type of Practice				
pediatric sub-specialist (n=35)	31 (89%)	4 (11%)	1.05	0.92-1.19
primary care (n=262)	222 (85%)	40 (15%)		
Urban Practice ^{b, c}				
yes (n=100)	90 (90%)	10 (10%)	1.08	0.99-1.19
no (n=196)	163 (83%)	33 (17%)		
Hospital bed size ≥ 500 ^c				
yes (n=58)	56 (97%)	2 (3%)	1.19	1.10-1.30
no (n=214)	173 (81%)	41 (19%)		
Care for child with HIV/AIDS ^c				
yes (n=55)	48 (87%)	7 (13%)	1.04	0.93-1.17
no (n=231)	194 (83%)	37 (16%)		

^a Omitted from this table are 38 physicians who did not indicate how often they report children with HIV infection.

^b Defined as one of the three largest counties: Charleston, Greenville and Richland.

^c Omitted from the prevalence ratio calculations are missing values for urban practice (n=1), hospital bed size (n=25) and care for a child with HIV/AIDS (n=11).

patients (two percent), and the physician making the diagnosis will report (two percent). No reason was indicated by three (60 percent) of the never reporters, one (17 percent) of the occasional reporters and 13 (39 percent) of the usual reporters.

Of the physicians who indicated who they perceived to be responsible for reporting children, 274 (82 percent) selected the primary care physician/pediatrician. Other responses were laboratories (27 percent), consulting specialty physician (26 percent), hospital infection control practitioner (21 percent) and ob/gyn physician (17 percent). Half of the physicians selected one party and 31 (nine percent) of the physicians indicated that all five are responsible for reporting.

DISCUSSION

HIV reporting for children is generally accepted by the surveyed South Carolina physicians. A similar response to AIDS

reporting was noted in the 1989 South Carolina survey in which 88 percent of the physicians indicated they would usually or always report persons with AIDS by name.¹ The apparent acceptance of named reporting for HIV infection in children may reflect the medical communities' trust in DHEC's management of HIV reports and protection of confidentiality.

Nevertheless, among the 44 physicians who did not always report, the two most commonly indicated reasons for not always reporting were concern that discrimination against the child and/or the family may occur as a result of reporting (n=12), and that the confidentiality of reported children will not be maintained (n=10). These concerns persist in spite of a state statute mandating protection of the confidentiality of the names of persons reported with HIV infection⁴ and that there have been no breaches of confidentiality for reported AIDS cases in this state or in health

TABLE 2.
REASONS INDICATED BY PHYSICIANS WHO DO NOT ALWAYS REPORT
HIV-INFECTED CHILDREN TO DHEC.^a (N=44)

Reason	Reporting Frequency		
	usually (n=33)	sometimes (n=6)	never (n=5)
I am concerned that discrimination against the child and/or the family may occur as a result of reporting. (n=12)	7 (21%)	4 (67%)	1 (20%)
I am concerned that the confidentiality of reported children will not be maintained. (n=10)	5 (15%)	4 (67%)	1 (20%)
I don't report children that I think may have been reported previously by someone else. (n=8)	7 (21%)	1 (17%)	0 (0%)
I don't report children if I think they have been reported in other states. (n=1)	1 (3%)	0 (0%)	0 (0%)
The reporting process is cumbersome. (n=4)	3 (9%)	1 (17%)	0 (0%)
I might forget. (n=2)	2 (6%)	0 (0%)	0 (0%)
I don't treat pediatric AIDS patients. (n=1)	1 (3%)	0 (0%)	0 (0%)
The physician making the diagnosis will report. (n=1)	1 (3%)	0 (0%)	0 (0%)
Did not mark any reason. (n=17)	13 (39%)	1 (17%)	3 (60%)

^a Columns don't total 100% because multiple responses were appropriate.

departments nationwide.⁵

Perceived responsibility for reporting influences a physician's decision to report. Among physicians who do not always report, 20 percent indicated not reporting due to their perceptions someone else had reported or it was the diagnosing physicians responsibility to report. The primary care physician/pediatrician was the most commonly identified party responsible for reporting HIV-infected children (82 percent) as was the primary care physician for reporting AIDS (59 percent) in the 1989 AIDS reporting study. A small percentage of physicians (nine percent) responded that everyone should report HIV infection. A high level of case ascertainment requires that all parties mandated to report (physicians, laboratories, and hospital infection control practitioners) assume responsibility for submitting HIV reports which can be unduplicated and confirmed by DHEC's HIV/AIDS surveillance staff.

South Carolina physicians' support for reporting HIV-infected children may reflect the physicians' desire to link HIV-infected children with services and resources. Special-

ized medical care and interdisciplinary and comprehensive support services have been offered to HIV-infected children and their families since 1986 at the Medical University of South Carolina (MUSC). To improve statewide access to comprehensive case management and care for children exposed to or infected with HIV, MUSC and DHEC coordinated and expanded the network of local, regional and tertiary care centers that had begun to provide care to HIV-infected children. The collaboration between centers is expected to improve patient tracking, case management and reporting. Improved HIV reporting should result as more children with known HIV infection are referred to these centers, which in turn report all HIV-infected children to DHEC.

DHEC uses HIV reports to target health education and early intervention programs, provide counseling and testing including CD4+ T-lymphocyte testing, make referrals, monitor trends and direct planning for allocation of services.⁶ These benefits can be maximized by early HIV detection and reporting. HIV infection recognized and reported soon

after transmission is more useful for promptly identifying recent changes in trends of HIV transmission and disease. Consequently, interventions can be targeted appropriately and respond more rapidly and effectively.

New reports of HIV infection in children may signal poor access to health care now that Zidovudine administered during pregnancy has been shown to reduce vertical transmission from 25 percent to eight percent.⁷ Since most HIV-infected children are infected perinatally, offering routine, voluntary HIV testing to pregnant women has been recommended⁸⁻¹⁰ for early detection.

South Carolina physician's HIV reporting practices for children are encouraging, yet physician responsibility for reporting and concerns about discrimination and confidentiality must be addressed to improve HIV reporting. □

ACKNOWLEDGEMENTS

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REFERENCES

1. Jones JL, Rion P, Garrison C, et al: Physician and infection control practitioner HIV/AIDS reporting characteristics. *AJPH* 82:889-891, 1992.
2. SC Code Ann. Sections 44-29-10, 70 and 80 (Supp. 1989).
3. Dean AG, Dean JA, Dicer RC: EPI Info, Version 5: A word processing, database, and statistics program for epidemiology on microcomputers. US Incorporated, Stone Mountain, GA, 1990.
4. SC Code Ann. Section 44-29-135 (Supp. 1989).
5. Francis DP, Singleton JA: Reporting of HIV-1 infection through the provision of essential services. *J Acquir Immune Defic Syndr* 6:285-286, 1993.
6. Centers for Disease Control: Public health uses of HIV infection reports - South Carolina, 1986-1991. *MMWR* 41:245-249, 1992.
7. Spector SA: Pediatric antiretroviral choices. *AIDS* 4:S15-S18, 1994.
8. Heagarty MC, Abrams EJ: Caring for HIV-infected women and children. *N Engl J Med* 326:887-888, 1991.
9. DiFrancisco E: Routine prenatal HIV testing more effective than recommended policy. *Infect Dis Children* 3:3, 1990.
10. Cozen W, Mascola L, Enguidanos R, et al: Screening for HIV and Hepatitis B virus in Los Angeles County Prenatal Clinics: A demonstration project. *J Acquir Immune Defic Syndr* 6:95-98, 1993.

MEASLES CONTROL IN INSTITUTIONAL SETTINGS*

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INTRODUCTION

Measles is a highly contagious viral infection which affects all unimmunized populations throughout the world. Despite the widespread use of safe and effective measles vaccines, first licensed 30 years ago, measles continues to be a leading cause of death among children in developing countries. In the United States, measles morbidity has declined by 99 percent compared to the pre-vaccine era.¹ In November 1993, for the first time since measles reporting began in 1912, there were no reported cases of the disease during three consecutive calendar weeks suggesting that there are now periods in which transmission of the measles virus in the United States is nearly interrupted. However, large community outbreaks experienced by several cities in 1989 - 1991 serve as reminders that the measles virus exhibits an extraordinary capacity to find susceptible sub-populations in which transmission can be sustained even though vaccine coverage in the population as a whole may be high.

During the past decade, numerous outbreaks of measles in institutional settings, especially in schools, have been well documented.² Reports that such outbreaks can occur even in highly immunized populations led us to examine whether a pediatric population in a residential mental health facility might also have susceptible children present

in numbers sufficient to sustain an outbreak should wild measles virus be introduced. We report here on a measles serological study of our population, on ambiguities and problems faced in interpreting the results, and on implications for measles prevention efforts in closed populations.

METHODS

Patient Population: Our study population was drawn from a state child and adolescent inpatient psychiatric facility to which patients are referred from throughout South Carolina for evaluation and treatment of emotional and behavioral problems. During an 11-month period measles serologies were obtained on 314 consecutive admissions.

The median age of the children was 14 years (range four to 17). The children were 57.6 percent Caucasian, 41.0 percent African-American, 0.3 percent Hispanic, 0.3 percent native Americans, and 0.6 percent of unknown racial and ethnic background.

Serological Studies: Serum samples for all the study subjects were tested for measles antibodies by the Bureau of Laboratories of the South Carolina State Department of Health and Environmental Control (DHEC) by means of a commercial enzyme immunoassay (EIA) (Elisa-stat Whitaker Walkersville, MD).

Twenty-one of the specimens, including samples which had been found to have positive, equivocal, and negative results, were also tested by the Measles Laboratory at the U. S. Centers for Disease Control (CDC). The

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CDC employed an in-house indirect EIA test which uses the measles virus nucleoprotein as the capture antigen.³

Documentation Of Vaccination: The DHEC Division of Immunization provided assistance in searching for documentation of measles vaccination from medical and school records for those children found to have negative antibody titers.

Statistical Analysis: Data were computerized and analyzed using Epi Info Version 5, a public domain software package for data management and statistical analysis from the CDC. Tests for significance of the difference between proportions were done using the Chi-square test.

RESULTS

Demographic characteristics of the study population as well as the results of the initial antibody tests are summarized in Table 1. Overall, the state laboratory reported 42 children with negative antibody titers and 19 with

equivocal titers. There were no differences in the proportion of negative antibody titers in males, 13.3 percent, and females, 13.7 percent ($p = 0.83$). However, a significant difference was observed between the proportion of negative antibody titers in Caucasians, 18.2 percent, and African-Americans, 6.2 percent, ($p = 0.002$). Negative antibody titers were highly associated with age ($p = 0.007$). All of the negative antibody titers ($N = 42$) occurred in children between ages 11 and 17 and 70 percent of the negative cases were 13 to 15 years old. There was no apparent relationship between psychiatric diagnosis and measles titer standing.

Twenty-one specimens were tested both at the state laboratory and at CDC. All five specimens found to be positive at the state laboratory were also reported as positive at the CDC. Of the four specimens reported as equivocal by the state laboratory, two were reported as positive and two as negative by the CDC. Of the 12 specimens reported as negative by the state lab, eight were also found to be negative at CDC, the remaining

TABLE 1
ADMISSION MEASLES ANTIBODY TEST RESULTS
ACCORDING TO SEX AND RACE

Group	Total	Positive No. (Pct)	Equivocal No (Pct)	Negative No. (Pct)
All admissions	314	253 (80.6)	19 (6.1)	42 (13.4)
By Sex (1) $P=0.833$ (*)				
Males	211	169 (80.1)	14 (6.6)	28 (13.3)
Females	102	83 (81.4)	5 (4.9)	14 (13.7)
By race (2) $P=0.002$ (*)				
White	181	135 (74.6)	13 (7.2)	33 (18.2)
Black	129	116 (89.9)	5 (3.9)	8 (6.2)

(*) chi-square test

(1) sex not recorded for one patient

(2) four patients were classified as "other" than white or black

four being reported as positive or equivocal.

Attempts to locate immunization records for 28 of the 42 children with negative titers were successful. All 28 had received MMR in the past. Four of these had received a single MMR prior to 15 months of age (range 10-14 months). Two patients had documentation of having received two doses of MMR prior to admission, with the first dose having been given at 10 and 11 months of age respectively. The other 22 children received MMR at 15 months or later.

DISCUSSION

Atkinson et al have shown that the principal cause for the measles epidemics which struck a number of large urban areas in the United States in 1989 and 1990 was the failure to achieve high vaccine coverage among pre-school aged children in inner-city areas.⁴ However, other well-documented measles outbreaks in the past 10 years have occurred in highly vaccinated populations. Such issues as primary and secondary vaccine failure, as well as other less understood reasons for vaccine failure, play an important role in measles control.

Krober et al reported that primary vaccine failure (up to 21 percent) may occur when measles vaccine is given to infants with colds.⁵ One hypothesis is that viral respiratory infections may interfere with normal antibody response to measles vaccination because of interferon induction. Nonetheless, current recommendations of the CDC and of the American Academy of Pediatrics are that MMR, and indeed all vaccines, may be given even to infants who have mild respiratory infections.⁶

Almost all infants acquire passive immunity against measles in utero as the result of trans-placental transfer of maternal IgG antibodies. There is some evidence that infants born to mothers whose immunity is derived from vaccination acquire lower levels of antibody and lose antibody at an earlier age than infants born to mothers with immunity acquired as the result of natural infection.⁷

Also to be considered, however, is the phenomenon of secondary vaccine failure, defined as waning immunity over time, a phenomenon which may become apparent only after the passage of years.⁷ Paradoxically, this phenomenon may become more important as measles control efforts improve, since these efforts reduce transmission of wild measles virus in the community, and thus decrease the likelihood that immunized persons will have their antibody titers "boosted" through exposure to wild virus.

In our study all the children who had negative or equivocal titers were born prior to September 1980 (Table 1). At least three factors may contribute to this observation. First, only our youngest children are likely to have received two doses of MMR since the "two measles shots" vaccination policy was not adopted in this country until 1989. Second, older children, even those who had a good serological response to the vaccine, may simply have had their antibody titers gradually decline over time to levels which are presently under the cut-point used to report seropositivity by the laboratory. Finally, since vaccines manufactured prior to 1979 had lower thermal stability and lower virus titers, we, in keeping with the line of reasoning proposed by Cote et al⁸ speculate that some of our seronegative patients may thus have had true primary vaccine failure. In a typical practice setting it is usually not possible, when faced with an individual child who has a negative antibody test, to distinguish between these possibilities.

It has been found that children who exhibit a negative titer after an initial dose of MMR are also more likely to fail to seroconvert even after a second MMR.^{8,9} An alternative strategy could thus include rescreening for antibodies four weeks after the second dose. In our institutional setting, we have found this approach to be cost-effective since (1) our cost for antibody screening is considerably less than the cost of a dose of MMR and since (2) children are having blood drawn on admission in any case.

We recognize that such an approach may not be feasible in ambulatory settings where blood is not being drawn for other reasons.

Because this study was carried out in a psychiatric hospital, there was some interest in examining the relationship between psychiatric diagnosis and measles antibody titers. However, no such relationship was noted.

We did observe (Table 1) a significantly higher proportion of negative titers in Caucasians than in African-Americans. Struewing et al also reported higher negative titers in Caucasians compared to African-Americans in his serosurvey of U.S. military recruits (19.7 vs. 5.6 percent), suggesting that this pattern is reflected nationally.¹⁰ The biological basis for this observation is not clear, and we can only speculate as to whether this might be the result of genetic or other factors like greater opportunity for exposure to "wild measles virus" in the African American population.

Although current public health policies have largely controlled measles in the United States, further progress toward elimination may require additional cost-effective and efficient strategies. In our study, conducted in an institutional setting, antibody testing prior to revaccination was found to be a cost effective and efficient way to assure that no susceptibles remained in our population.

SUMMARY

This paper reports on the utility of screening pediatric psychiatric admissions for the presence of antibodies to measles to determine the need for administration of MMR Vaccine to 314 children admitted over an 11-month period. Four fifths (80.6 percent) of the children had positive antibody tests when screened. No sex difference in antibody prevalence was noted but Caucasians were more likely (18.2 percent) than African American (6.2 percent) to have negative antibody tests. No relationship was noted between psychiatric diagnosis and antibody test results.

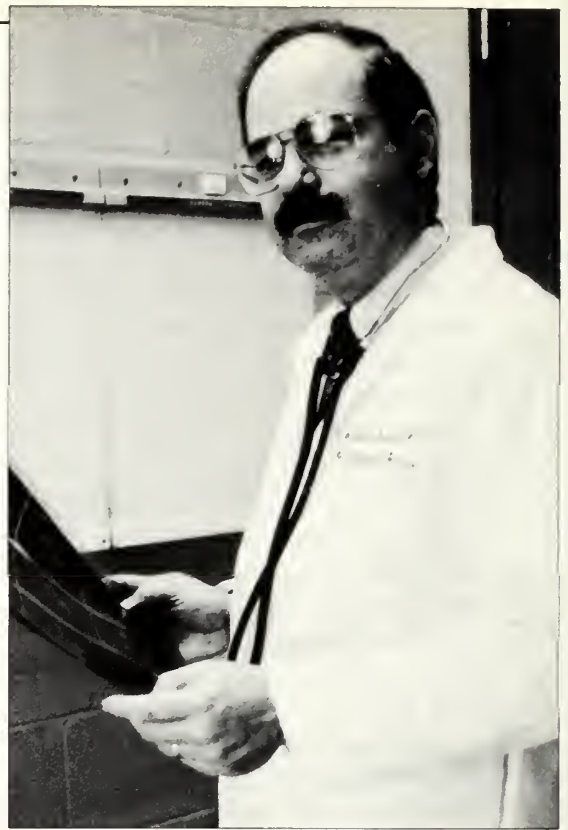
A substantial proportion of adolescents have negative or equivocal measles antibody tests and interpretation of such results may be difficult. Antibody testing is cost-effective in institutional settings and, in the future, may become so in selected ambulatory settings. □

REFERENCES

1. Atkinson WL, Hadler SC, Reeds, Orenstein WA. Measles Surveillance - United States 1991. MMWR; 41, No. SS-6, 1992.
2. Matson DO, Byington C, Canfield M, Albrecht P, Feigin RD. Investigation of a measles outbreak in a fully vaccinated school population including serum studies before and after re-vaccination. *Pediatr Infect Dis J*; 12: 292-299, 1993.
3. Hummel KB, Erdman DD, Heath J, Bellini WJ. Baculovirus expression of the nucleoprotein gene of measles virus and utility of the recombinant protein in diagnostic enzyme immunoassays. *J Clin Microbiol*; 30:2874-2880, 1992.
4. Atkinson WL, Orenstein WA. The resurgence of measles in the United States 1989 - 1990. *Ann. Rev. Med*; 43: 451-463, 1992.
5. Krober MS, Stracener CE, Bass JW. Decreased measles antibody response after measles-mumps-rubella vaccine in infants with colds. *JAMA*; 265: 2095-2096, 1991.
6. Centers for Disease Control. General Recommendations on Immunization. Recommendations of the Immunization Practices Advisory Committee (ACIP). MMWR; 42:No. RR-1, 1994.
7. Johnson CE, Nalin DR, Chui LW, Whitwell J, Marusyk RG, Kumar ML. Measles vaccine immunogenicity In 6- versus 15-month-old infants born to mothers in the measles vaccine era. *Pediatrics*; 93: 939-943, 1994.
8. Cote TR, Sivertson D, Horan JM, Lindegren ML, Dwyer DM. Evaluation of a two-dose measles, mumps, and rubella vaccination schedule in a cohort of college athletes. *Pub Health Rep*; 108:431-435, 1993.
9. Cohn MT, Robinson ED, Faerber M, et al. Measles vaccine failures: Lack of sustained measles-specific immunoglobulin G responses in revaccinated adolescents and young adults. *Pediatr Infect Dis J*; 3: 34-38, 1994.
10. Struewing JP, Hyams KC, Tueller JE, Gray GC. The risk of measles, mumps, and varicella among young adults: A serosurvey of US Navy and Marine Corps recruits. *Am J Pub Health*; 83:1717-1720, 1993.

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Joy Drennen, Editor

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Contributions welcomed

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November, 1995

MEDICARE UPDATE

The November, 1995 *Medicare Advisory* contains important information for you and your staff such as covered vaccines; 1996 program changes and update workshops; the new remittance advice; and much more.

Provider Performed Microscopy: Three new Provider-Performed Microscopy Procedures (PPMP, formerly called the Physician-Performed Microscopy Procedures), were established under CLIA:

1. Fecal Leukocyte Examination – G0026
2. Semen Analysis: presence and/or motility of sperm excluding Huhner test – G0027
3. Nasal Smear for Granulocytes – 89190

Site-Specific Procedure and Diagnosis Codes: When the description of a CPT-4 procedure code includes reference to a specific region of the body, you should check the diagnosis code you use carefully. Diagnosis codes (ICD-9-CM) may also refer to a specific region of the body. If the procedure and diagnosis codes refer to different anatomical sites, Medicare may deny the service with action code JP – Medicare does not pay for the services for the condition stated – because the diagnosis code does not support the service rendered.

New Correct Coding Combinations: In 1994, HCFA contracted with AdminaStar Federal to define correct coding practices that would be the basis of national Medicare policy for payment of claims using the AMA CPT-4 system. With HCFA approval, a code matrix, or correct coding combinations, is being incorporated into the Medicare carrier's claims processing systems. The matrix will automatically identify inappropriate CPT code combinations

and determine payment. Existing national Medicare payment policies are not changed by the correct coding policy.

Two main types of code combinations will be implemented in January, 1996:

- Comprehensive and component code combinations
- "Mutually exclusive" coding combinations

In conjunction with the new correct coding initiative, HCFA has established a new temporary national level II modifier which goes into effect on January 1, 1996 – Modifier GP: Distinct Procedure Service.

Please refer to your November *Medicare Advisory* for a summary of the correct coding policy.

End Stage Renal Disease Facilities Approved For Ambulance Transport: The following renal dialysis centers meet the criteria for an approved destination of Medicare ambulance services for nonskilled facility patients effective September 15, 1995: Easley Dialysis Center and Lexington Dialysis Center.

Ambulance Transport of Nursing Home Patients to Physicians' Office: Medicare will not cover ambulance transport of a nursing home patient to a physician's office if it would be less expensive for the physician to visit the patient. For more information on ambulance transport to and from a physician's office, please refer to page 18 of the July, 1995 *Medicare Advisory* and page 2 of the February, 1995 *Medicare Advisory*.

□

MEDICAID UPDATE

1995 Physicians' Current Procedural Terminology (CPT) Codes: Effective with dates of service on or after January 1, 1996, the Department of Health and Human Services (DHHS) will accept the new 1996 CPT codes. Either the previous 1995 or the new 1996 CPT procedure codes may be billed during the grace period from January 1, 1996, through March 31, 1996. Effective with dates of service on or after April 1, 1996, only the 1996 CPT procedure codes will be accepted.

Provider Tax Identification Information: The DHHS was notified by the Internal Revenue Service (IRS) of inconsistencies with Medicaid provider files and IRS records. If you received a certified letter dated October 20, 1995, for a first B Notice or second B Notice, please respond prior to December 14 as instructed. The IRS requires the DHHS to withhold 31 percent of all payments for those physicians who do not respond before December 14, 1995, until the B Notice is resolved.

Surgery Billing Workshops: The Department of Physician Services will be conducting statewide Medicaid workshops to review the material detailed in the upcoming bulletin concerning surgical claims processing. There will be no other topics on the agenda except surgery billing requirements and changes to our surgical reimbursement methodology. (However, provider workshops

for all physicians are being planned for 1996, following the distribution of the revised Medicaid Manual.)

The workshops are free of charge and any Medicaid provider who bills surgical procedure codes is welcome to attend. Each workshop will begin promptly at 10:00 am. Please bring the surgery bulletin and materials needed for taking notes. The following is a list of dates and locations of the upcoming workshops:

Tuesday, November 21, 1995, Columbia, SC
DHEC - Peeples Auditorium

Wednesday, November 29, 1995, Florence, SC
Florence/Darlington Technical College
Building 400, Room 401

Thursday, November 30, 1995, Charleston, SC
MUSC - Psychology Auditorium

Tuesday, December 5, 1995, Greenville, SC
Greenville Memorial Hospital
Medical Staff Auditorium

If you have any questions about the workshops, please call your program manager at (803) 253-6134. □

HEART ASSOCIATION RESEARCH GRANTS

Grant-in-aid and Fellowship applications are now available from the American Heart Association, South Carolina Affiliate, Inc., with a deadline of December 4, 1995, for submission to the Association's Research Committee. *Information and application forms may be obtained from the American Heart Association, South Carolina Affiliate, Inc., PO Box 6604, Columbia, SC 29260, Telephone: 738-9540 in Columbia. Awards are activated beginning July 1, 1996.*

General requirements are that applicants must have advanced degrees and contemplate significant basic or cardiovascular research in a non-profit institution with adequate facilities for their work.

This research program is separate from that of the American Heart Association, National Center, which also makes research awards to scientists in SC. Deadlines are June 1, 1996, for Fellowships and July 1, 1996, for Grants-in-Aid. Applications will be available in January, 1996. *Those interested in inquiring about the national program may write the Director of Research, American Heart Association, 7320 Greenville Avenue, Dallas, TX 75231.*

The National and South Carolina Heart Associations' research programs are financed by public contributions. □

SCMA MEMBERS' INSURANCE TRUST

Exciting news from the SCMA Members' Insurance Trust (MIT), our own health insurance plan, has been sent to every physician in the state. The MIT health insurance is available to all SCMA members, their dependents, and their employees.

This mailing announces a 12 percent rate reduction and new added benefits, such as preventive care. There are also new choices in options ranging from a \$0 to a \$1,000 deductible.

To obtain more information, call the SCMA in Columbia at 798-6207 or statewide at 1-800-327-1021 and speak with Vic Paschal (ext. 245) or Nancy Caniff (ext. 251). □

CAPSULES

Boyce G. Tollison, MD, Easley, has been named the 1995 Family Physician of the Year by the SC Academy of Family Physicians. □

PHYSICIANS CARE NETWORK UPDATE

The Physicians Care Network has added yet another employer group, Collum's Lumber, effective November 1, 1995. Allendale Hospital has verbally agreed to join the PCN, thereby making a total of 50 hospitals.

SCMA ANNUAL MEETING APRIL 25-28, 1996

*Charleston Place Hotel
(Formerly the Omni)
Charleston, SC*

*House of Delegates Meetings
Specialty Society Meetings
Continuing Medical Education
Exhibits
And much more*

MARK YOUR CALENDARS NOW

CODING SEMINAR SERIES

*January 15-18 & February 5-8, 1996
9:00 am-4:00 pm, Registration: 8:30 am*

Our ever-popular coding workshops have taken on a new dimension. We have refined our ICD-9-CM course and now offer a basic and an advanced course, just as we did last year with our CPT coding courses. Taught by Wanda Adams, CPC, of AMA Financing and Practice Services, the basic courses are designed to help those with less than five years' coding experience, while the advanced courses are more in tune to the sophisticated problems of the long-time coder. These courses will be offered as a week-long series in Columbia and in Charleston. Tuition for the basic courses is \$150 for SCMA members and \$200 for non-members. Tuition for the advanced courses is \$175 for SCMA members and \$225 for non-members. Staff of SCMA physician members are eligible for the member tuition.

Sheraton Hotel and Conference Center, Columbia

CPT Coding for Doctors' Offices.....January 15
ICD-9-CM Coding for Doctors' Offices.....January 16
Advanced CPT Coding and Reimbursement Issues.....January 17
Advanced ICD-9-CM Coding and Reimbursement Issues...January 18

Radisson Inn Charleston Airport, Charleston

CPT Coding for Doctors' Offices.....February 5
ICD-9-CM Coding for Doctors' Offices.....February 6
Advanced CPT Coding and Reimbursement Issues.....February 7
Advanced ICD-9-CM Coding and Reimbursement Issues...February 8

For more information, call Ginny Comer at 798-6207, ext. 253, in Columbia or 1-800-327-1021 statewide. □

EMERGENCY MEDICAL SERVICES – DO NOT RESUSCITATE ORDERS

by Stephen P. Williams, J. D.

In recent years, the South Carolina General Assembly provided progressive mechanisms for South Carolinians to state their wishes about end-of-life decisions through the Death With Dignity Act and the Health Care Power of Attorney Act. Even with these types of advance directives, citizens with terminal illnesses continued to face problems regarding their wishes not to receive resuscitative treatment from emergency medical personnel. Because of their statutory and regulatory duties, Emergency Medical Services (EMS) workers could not legally follow these directives and were required to always provide resuscitative measures, in contravention of the patient's advance directives. When terminally ill patients began to die at home from their illness and panicking family members called 911, these patients were often resuscitated with emergency life support treatment. Sometimes they were delivered to the hospital emergency room with significant irreversible brain damage caused by lack of oxygen prior to and during the resuscitative process, extending their lives in a manner the patient had specifically sought to avoid.

In 1994, the South Carolina General Assembly responded to this problem with passage of the Emergency Medical Services Do Not Resuscitate Order Act. The Act is codified at S. C. Code Ann. § 44-78-10 *et. seq.* (1995 Cum. Supp.) Regulations detailing procedures for EMS workers to follow in carrying out the purposes of the Act were approved by the General Assembly in 1995. (See, DHEC Regulation R 61-7, § 1200 *et. seq.*)

The EMS-DNR Order works very differently from a Living Will or Health Care Power of Attorney, which are available from a wide range of sources and are completed by the patient. Further, the patient can be in perfectly good health and complete one of those documents. In contrast, *the EMS-DNR Order can only be issued by a physician* to a patient who requests the order and who has a terminal condition as defined in the Act. That is, the patient must have an incurable or irreversible condition that within reasonable medical judgment could cause death within a reasonably short period of time if life-sustaining procedures are not used. This definition of terminal illness is consistent with the definition of a terminal condition found in the S. C. Death with Dignity Act.

Additionally, a surrogate for the patient under the Adult Health Care Consent Act or an agent for the patient under the Health Care Power of Attorney Act can also request that a physician issue the EMS-DNR order for a patient unable

to communicate with a physician himself or herself.

If EMS workers are called to provide services to a patient who has obtained an EMS-DNR order, and the EMS workers find the patient in cardiac arrest, pulmonary arrest, or cardiopulmonary arrest, they **must not** utilize any resuscitative treatment. Resuscitative treatment is defined in the Act as artificial stimulation of the cardiopulmonary systems of the body, through either electrical, mechanical, or manual means including, but not limited to, cardiopulmonary resuscitation. EMS workers in this situation must supply that degree of care necessary to ensure comfort of the patient called for under circumstances that exist at the time treatment is rendered.

In layman's terms, the Act assures that a patient who has a terminal illness and desires not to be resuscitated should his or her heart stop beating and/or respiratory function cease will not be resuscitated by EMS workers.

The Act sets forth a specific form to be used by physicians in issuing the EMS-DNR order. The form requires the date, patient, agent or surrogate signature, and the physician's signature, address and phone number. DHEC has created a version of the form to be used by health care providers to assure uniformity and quick recognition of the document by EMS workers.

The order may be revoked by the patient by an oral statement to EMS workers, or by mutilating, obliterating or destroying the form itself, in any manner.

Physicians and EMS personnel are also granted limited immunity under the Act when complying with its terms in good faith.

It is anticipated the orders will be requested by relatively few patients with a terminal illness. However, organized groups, such as Hospice, may inform patients who have strong feelings about resuscitation of the availability of the orders. These orders will also likely be helpful when transporting terminally ill patients from one facility, such as a nursing home, to another facility. Physicians should use caution in signing these orders. If possible, talk to the patient and be sure he or she understands the consequences of the order.

Following is a sample form for office use. *If you need additional forms, please contact DHEC's Emergency Medical Services Division in Columbia at (803) 737-7204.* □

**SOUTH CAROLINA
EMERGENCY MEDICAL SERVICES**



DO NOT RESUSCITATE ORDER

NOTICE TO EMS PERSONNEL

This notice is to inform all emergency medical personnel who may be called to render assistance to _____ that he/she has a terminal condition which has
(Name of Patient)
been diagnosed by me and has specifically requested that no resuscitative efforts including artificial stimulation of the cardiopulmonary system by electrical, mechanical, or manual means be made in the event of cardio-pulmonary arrest.

REVOCATION PROCEDURE

THIS FORM MAY BE REVOKED BY AN ORAL STATEMENT BY THE PATIENT TO EMS PERSONNEL, OR BY MUTILATING, OBLITERATING, OR DESTROYING THE DOCUMENT IN ANY MANNER.

Date: _____ Patient's Signature (or Surrogate or Agent) _____

Physician's Signature _____ Physician's Address _____

Physician's Telephone Number _____

DNR INFORMATION FOR THE PATIENT, THE PATIENT'S FAMILY, THE HEALTH CARE PROVIDER AND EMS PERSONNEL

1. Responsibilities of the Patient or his/her Surrogate or Agent
The patient and his/her surrogate or agent:

Will make all care givers aware of the location of the EMS DNR Form and will ensure that the form is displayed in such a manner that it will be visible and available to EMS personnel.

Understand the consequences of refusing resuscitative measures.

Are aware that if the form is altered in any manner resuscitative measures will be initiated.

Understand that in all cases, supportive care will be provided to the patient.

2. Responsibilities of the Health Care Provider (Physician)
The patient's physician:

Has determined that the patient has a terminal condition.

Has completed the patient's EMS DNR Form.

Has explained to the patient and family the consequences of withholding resuscitative care; the medical procedures that will be withheld and the palliative and supportive care that will be administered to the patient.

3. Responsibilities of EMS Personnel
EMS personnel:

Will confirm the presence of the EMS DNR Form and the identity of the patient.

Upon finding an unaltered EMS DNR Form, will withhold or withdraw resuscitative measures such as CPR, endotracheal intubation or other advanced airway management, artificial ventilation, defibrillation, cardiac resuscitation medication and related procedures.

Will provide palliative and supportive treatment such as suctioning the airway, administration of oxygen, control bleeding, provision of pain and non-cardiac medications, provide comfort care and provide emotional support for the patient and the patient's family.

Will assure that the DNR Form accompanies the patient during transport.

BACKFIRE: AHCPR PRACTICE GUIDELINE FOR ACUTE LOW BACK PAIN

RUDOLPH H. de JONG, M. D.*

The most frequent reason for a patient to visit his/her physician is *PAIN*; and the one complaint near the top of a long list of aches and pains is *low back pain*. Worse, for people under 45 low back problems are the most common cause of disability.¹ Clearly, treating low back pain (*LBP*) early and adequately carries enormous societal consequences in cost, productivity, workdays lost, and in personal misery.²

No wonder then that the Public Health Service has tackled this problem with vigor, frankness and laudable courage; for reducing disability and minimizing overtreatment will save the Government billions and South Carolina millions of dollars. At painful issue is whether the executive agent (AHCPR; Agency for Healthcare Policy and Research) measured up to this complex, unenviable and likely thankless task with its customary demographically and occupationally balanced "expert panel" consensus document.**

This paper summarizes Guideline conclusions, recommendations and omissions, and expands on some contentious practice issues of immediate concern as much to "gatekeeper" physicians as to "specialist" practitioners.

*Address correspondence to Dr. de Jong at Carolina Pain Center, HealthSouth, 17 Richland Medical Park, Columbia, SC 29203.

***"Acute Low Back Problems in Adults: Assessment and Treatment"

(a) Clinical Practice Guideline (complete text & tables); AHCPR document number 95-0642

(b) Quick Reference Guide for Clinicians (clinical guideline); AHCPR document number 95-0643

(c) Understanding Acute Low Back Problems (patient guide); AHCPR document number 95-0644

Call AHCPR orderline (800/358-9295) for documents 95-0643 and 95-0644 at no charge; or call InstantFAX (301/594-2800). The complete "Clinical Practice Guideline" is sold (\$45.50) by the Government Printing Office.

For a consensus reached by a 23-member panel comprising lay, consumer, clergy, legal, nursing, behavioral, therapist, chiropractic, osteopathic and allopathic representatives may be well suited to prescribing cost-effective healthcare strategies, but backfires when prescribing patient treatment protocols.

These guidelines now are in the public domain and widely accessible to the media—not to mention insurers, healthcare organizations, administrators and trial attorneys. In a frightening sense these well-intentioned guidelines assume the mantle of government-sanctioned practice standards, guiding utilization review and reimbursement for the healthcare industry; with denial (or worse) the penalty for deviation.

CONCEPT

Because of inherent evolutionary engineering flaws in adapting a spinal column designed for horizontal quadruped orientation to an upright biped position, man's lumbar spine is subject to stresses and strains that far exceed the original specifications. No wonder that at any given time about half the adult U. S. working population has back symptoms, sufficiently intense in some 15 to 20 percent to seek medical attention.¹

The good news is that about 90 percent of patients with acute LBP recover spontaneously within a month, with little or no medical intervention needed. The bad news is that we don't deal well with the residual 10 percent who don't improve within the magic one-month window, and who stand a fair chance to edge ever closer to the abyss of chronic intractable refractory back pain and attendant impairment.³

The Guideline's elemental philosophy—shift treatment focus from relief of pain to

return of functionality and activity tolerance—is a credit to the panel's common-sense approach. As is the thesis of triage and repeated reassessment to separate the 90 percent "will recover" majority from the 10 percent "red flag" few that demand immediate attention. Or (rephrased) separating myoskeletal from neurogenic/spondylitic back pain.

INITIAL ENCOUNTER

Few would (or could) find fault with the guideline's methodology for Patient Assessment, Medical History, Physical Examination or Behavioral Appraisal. These sections lay the foundation for establishing an initial baseline against which to gauge subsequent progress (or regression), offer sound criteria for identifying danger signals that call for further investigation (and perhaps intervention), and reason persuasively for eliminating unnecessary, uncomfortable, expensive and low-yield tests for simple self-limited back disorders.

The guidelines for uncovering function-threatening signs and symptoms are well-considered and inclusive, yet comprehensive. The factual algorithms help formulate an organized approach to call for help if and when needed. Table 1 (adapted from the Guideline) isolates the major threat factors ("red flags") of fracture, tumor, infection, or neural compression that demand further investigation and urgent attention.

TRIAGE

Following the above initial appraisal of *acute* (less than four weeks) low back pain with focused medical history and physical examination, patients can be triaged into three categories, plus a fourth exclusion group.

I. NONSPECIFIC: Mainly localized LBP with at most limited radiation to the buttocks. No red flags. No special studies needed in the first acute phase month, unless reassessment shows regression. Probably myoskeletal or postural ("sprains and strains"). Recovery,

TABLE 1
"RED FLAG" WARNINGS: HISTORY, SYMPTOMS, SIGNS

<u>FRACTURE</u>	<u>TUMOR OR INFECTION</u>	<u>NEURAL COMPRESSION</u>
<u>Major Trauma</u> – vehicle accident – steep fall	<u>Tumor</u> – under 20 or over 50 years – history of cancer – unexplained weight loss	<u>Saddle Anesthesia</u> – history – exam – bladder dysfunction – lax anal sphincter
<u>Minor Trauma</u> – elderly – osteoporosis	<u>Infection</u> – undiagnosed fever and chills – watch out for UTI – stiff neck – headache <u>Immune Suppression</u> – steroid therapy – transplant – HIV	<u>Leg Muscle Weakness</u> – gait imbalance – foot drop – knee extension (L3) – heel-walk (L4) – big toe extension (L5) – toe-walk (S1)

Adapted from AHCPR "Guidelines," Table 1'

with minimal intervention other than exercise or therapy, likely within a month.

II. SCIATICA: Lower extremity symptoms (pain, weakness, or both) originating in lower back. Suggests lumbosacral root or sciatic nerve compression. Requires further assessment, medication, and possibly referral for definitive correction. Motor weakness demands urgent investigation; otherwise, initiate conservative treatment and reassess frequently to gauge therapeutic response.

III. POTENTIALLY SERIOUS: The "*Red Flag*" category—possible traumatic or pathologic fracture, primary or metastatic tumor, infection (don't overlook hematogenous spread), spinal cord conus or lumbosacral root compression. Demands priority investigation, consultation, possibly referral.

IV. NON-SPINAL: The "*Red Herring*" category—vascular claudication, lumbosacral plexopathy (tumor, radiation), polyneuropathy, referred abdominal or pelvic pain, and so on.

THERAPEUTIC INTERVENTION

My bone of contention with the "Clinical Practice Guideline"—and one that concerns every physician treating LBP—lies with the therapies recommended or at least condoned, against the therapies considered of unproved or dubious benefit, or downright unwarranted. For instance, muscle relaxants are brushed off, and muscle trigger point injections condemned, yet these helped me (and others) get right back to work. On the other hand, spinal manipulation is considered of sufficient "proven" benefit to be recommended, based on the chiropractic literature. Hum!

No argument whatever that minimizing bed rest is beneficial, and that back rehabilitation should start soonest. It is the hint of authoritative practice standard and government sanction behind the praise and the condemnation that implies inappropriate treatment should one elect an alternate therapeutic approach.⁴ I

find that worrisome, if not frightening; and so should you.

Acetaminophen arguably is the *safest* analgesic, but whether it is as *effective* an analgesic as opioids is rather dubious. Many of us have seen cases of acute disc herniation or bone infection with pain so severe as to require relief with opioid therapy—doubtful that a handful of Tylenol or aspirin tablets would have done much good.⁵ The argument that one-third of patients given opioids respond poorly to, and/or progress to drug dependence is as patently absurd as is the recommendation to manipulate the spine in lieu of any medication at all. I doubt that the patient in agony with back pain would appreciate either a lecture on the evils of opioids or hands-on manipulation—all (s)he wants is immediate relief. No sane physician sanctions indiscriminate opioid use, but neither should we countenance needless suffering.

RED FLAG CONDITIONS

Although the triage algorithm for detecting potentially serious spine disorders will serve clinicians well, the means offered for treating red flag problems at times appear to be more panel majority vote than solid scientific fact. For instance, prognostic trial of non-invasive epidural steroid injection prior to surgical discectomy seems a sensible low-risk alternative when a bulging intervertebral disc causes lumbar radicular pain without motor deficit. This cost-saving therapy, often therapeutic of itself, is a common prelude to surgical intervention in the Midlands — and likely in the rest of the state.

To be sure, controlled studies of epidural steroid injection are few and seldom adequate, and the benefits are mostly anecdotal.⁶ But then, any treatment of low back pain, and I daresay including spine manipulation, remains a black art that, other than spontaneous recovery, has not yet found a fully satisfactory solution.⁷

STANDARD OF PRACTICE?

A balanced community cross-section commit-

tee may be the democratic way for formulating national consensus policy, but hardly seems the appropriate forum for judging—let alone making—clinical practice recommendations. The gravest practice concerns are:

- (a) By facile implication, therapeutic guidelines intended for managing benign self-limiting acute onset low back pain could well be extended to the 10 percent of patients with serious or refractory spine problems.
- (b) Likewise, patients with *chronic* intractable low back pain could well be lumped indiscriminately with the targeted *acute* pain population. Although the diagnostic criteria and therapeutic options are totally different for the *chronic* pain group, the temptation to cut costs may override patient interests.

Like it or not, a de facto practice standard for managing low back pain problems has been published—it will be read and quoted not just by physicians, but by carriers, hospital administrators, claims adjusters, workers compensation agencies, patient advocacy groups, journalists, Medicare/Medicaid agencies....and by trial attorneys. Become familiar with the "Quick Reference Guide for Clinicians," document why you selected a different treatment program, and make the patient part of the decision-making process. It will heal your patient, speed your claim, and save you grief in the future.

SUMMARY

The AHCPR "Guideline for Acute Low Back Problems in Adults" is a must-read for every South Carolina physician treating low back

pain. The 25-page pamphlet excels as a practical guide for swiftly triaging acute low back problems into the 90 percent majority who recover within a month, from the few "red flag" and "red herring" serious back problems requiring urgent attention. But the Guideline panel overstepped its policymaking mandate by venturing into the quicksand of treatment by committee edict, rather than by on-the-spot caretakers. The rumbling backfire is that U. S. Government document, intended as practice *guideline* for **routine acute back care**, will come to haunt us as a practice *standard* for **all back care**. One-size-fits-all proposals for the majority short-change the few with more demanding healthcare resource requirements. Be sure to read the pamphlet; your patients, insurers, providers, administrators, journalists and attorneys will! □

REFERENCES

1. USPHS Agency for Health Care Policy and Research: Acute low back problems in adults Assessment and Treatment. Clinical Practice Guideline. AHCPR Publication No. 95-0643, 1995 (25-page booklet).
2. Deyo RA, Cherkin D, Conrad D, Volinn E: Cost, controversy, crisis: low back pain and the health of the public. *Ann Rev Publ Health* 12 : 14 1-1 56, 1991.
3. Hasue M: Pain and the nerve root: an interdisciplinary approach. *Spine* 18:2053-2058, 1993.
4. Von Korff M, Barlow W, Cherkin D, et al: Effects of practice style in managing back pain. *Ann Intern Med* 121:187-195, 1994.
5. Saal JS: The role of inflammation in lumbar pain. *Phys Med Rehab* 4:191-198, 1990.
6. Bowman SJ, Wedderburn L, Whaley A et al: Outcome assessment after epidural corticosteroid injection for low back pain and sciatica. *Spine* 18:1345-1350, 1993.
7. Deyo RA: Fads in the treatment of low back pain. *N Engl J Med* 325:1039-1040, 1991.

SCHAMBERG'S DISEASE: A CASE REPORT

LESA BETHEA, M. D.*

The purpose of this report is to present and describe a case of Schamberg's Disease, a benign and poorly understood condition that can mimic serious causes of purpura.

CASE REPORT

A 71-year-old white male with a history of atrial fibrillation, hypertension, congestive heart failure, chronic obstructive pulmonary disease, chronic venous insufficiency and peptic ulcer disease presented with a one-week history of worsening pruritic rash on the legs, right arm and lower back. The patient denied any bleeding, fevers or insect bites. His medications included digoxin, lasix, vasotec, cardura and pepcid. Physical examination revealed, in addition to his chronic venous stasis dermatitis, small groups of rust-colored petechial - like lesions were scattered on the lower-legs, right inner forearm and lower back (Figure 1.)

Diagnostic Maneuver (Rumpel-Leede or Positive Tourniquet Test): An increase was noted in the number of lesions on the right lower forearm when the blood pressure cuff was inflated just above the patient's systolic blood pressure for one to two minutes.

Biopsy (Punch Biopsy 3mm x 2): The pathologist reported a mild superficial lymphocytic vasculitis in the upper dermis associated with extravasation of red blood cells. The pathologist also reported a mild capillary endothelial swelling.

Based on these findings, a diagnosis of Schamberg's Disease (Chronic Pigmented Purpura, Progressive Pigmented Purpuric

Dermatosis, Schamberg's Purpura, Purpura Pigmentosa Chronica) was made.

The patient was treated with an over-the-counter hydrocortisone and an oral antihistamine. Follow-up at one week revealed a decrease in the number of extent of lesions. A follow-up of four weeks showed the patient's lesions to have almost completely resolved. Only a few lesions remained on the lower legs.

DISCUSSION AND SUMMARY

The incidence and prevalence are unknown. There are only a few case reports in the literature. Though first described in children the disease is thought to be an uncommon pediatric problem. It is more common in males than females.



Figure 1.

*Department of Family and Preventive Medicine, University of South Carolina School of Medicine, 5 Richland Medical Park, Columbia, SC 29203.

The disease was originally described in 1901 by Schamberg in a 15-year-old boy as "diffuse, reddish-brown, non-elevated irregular oval patches" with borders consisting of "pin head size, reddish-brown, scaly elevated puncta or cayenne-pepper spots."

Patients usually present with asymptomatic rust-colored clusters of petechiae and brownish pigmentation still best described as Schamberg did originally. Mild erythema and scaling may sometimes cause itching. Lesions most commonly occur on the lower extremities, including the feet, but sometimes appear on the upper body. There are no diagnostic laboratory tests, and platelet counts and clotting factors are normal.

Simply put, this is a capillaritis with extravasation of red blood cells and pigment. Schamberg's original report, based on microscopy, was a "normal epidermis, and infiltrate of lymphocytes and polymorphonuclear cells in the sub-papillary and papillary portions of the cutis, dilated papillary blood vessels and lymph spaces, and proliferation of the endothelial lining of the blood vessels." Five different conditions share similarly histologies: Progressive pigmetary dermatosis of Schamberg, the annular telangiectatic purpura of Majocchi, the lichenoid purpuric dermatitis of Gourgerot and Blum, the eczematoid purpura of Doucas and Kapetanakis, and the localized variant termed lichen aureus. Most authors report a perivascular mononuclear infiltrate extending into the reticular dermis. Usually seen are extravasated erythrocytes with hemosiderin laden macrophages.

Lawler has found "aneurysmal dilation of

the dome portion of end-capillaries" in the superficial vascular bed. Rupture of the aneurysms results in purpura, and deposition of hemosiderin results in pigmentation.

Many causes have been proposed but none have been proven. Past theories include irritation from wool clothing, ingestion of acetylsalicylic acid, carbamols or meprobamate. Recent work by Aiba and Tajami¹ suggest a cellular immune reaction may play a part.

The differential diagnosis includes more serious entities: Henoch-Schoenlein purpura, drug sensitivity purpura, thrombocytopenia purpura, purpura due to infection, purpura due to blood dyscrasias, contact dermatitis, collagen vascular disease, paraproteinemia, cryoglobulinemia. The patient should be reassured that there is no systemic disease and informed that pigmentation may last for years and can be covered with cosmetics, such as Dermablend[®], if desired. Mild itching and erythema respond quickly to group V topical steroids. The lesions may last for months or years and present only a cosmetic problem. There is no associated hematologic or internal disease.²⁻⁴ □

REFERENCES

1. Aiba S, Tami H. Immunohistologic studies in Schamberg's Disease: Evidence for cellular immune reaction in lesional skin. *Archives of Dermatology*; 124: 1058-1062, 1988.
2. Habif TP. *Clinical Dermatology* 2nd Edition. C.V. Mosby Company, St. Louis, p.467, 1990.
3. Draelos ZK, et. al. Schamberg's purpura in children: case study and literature review. *Clinical Pediatrics*; 26(12): 659-661, 1987.
4. Kerem E, et. al. Chronic pigmented purpura: a case report of Schamberg's disease. *Clinical Pediatrics*; 26(12): 657-658, 1987.

Editorials

Guest editorials reflect the opinions of the authors and do not necessarily represent the opinions or policies of the officers and trustees of the South Carolina Medical Association.

—CSB

THE STARE THAT SAID IT ALL

She was 10 years old — small, frail, sweet smile, but afraid. In this small orphanage in south India's remote highland province of Tamil-Nadu, this child, one among 260, was diagnosed with rheumatic heart disease and mitral stenosis. She was symptomatic on the slightest exertion, and a previous echocardiogram had reported a severely restricted mitral valve area and a dilated left atrium. When I asked to examine the child, she walked up one flight of stairs to my room only to present with severe dyspnea and tachycardia. Her colorful sari danced to the rhythm of a heaving left precordium signifying marked cardiac enlargement. Easily palpable was the frightful rumbling grade four diastolic murmur of mitral stenosis with the pounding S1. The child's eyes reflected fear and despair as she and her family had been told that cure could only come by surgical open-heart repair — a financially hopeless option for them. In summary, she was in sentence of death, the only variable being — when?

Four of us were visiting the orphanage representing our church which had offered support to this institution for about 17 years. We had come to bring whatever assistance we could to the small orphanage which was nestled in a small valley surrounded by lush green jungle covered mountains.

As I pondered the plight of the small frail child, I requested a consultation with a physician in a local village. This doctor attended those in the institution when illness required his services, and he was gracious in receiving us in his home one afternoon after office

hours. After delightful dish of sliced mangos and a cup of coffee, I showed him the echocardiogram that had confirmed tight mitral stenosis, and I inquired as to the possibility of balloon dilatation of the valve since this would be a much less expensive procedure than open-heart repair. Third world countries with very high incidence of rheumatic heart disease have necessarily adapted this form of valvuloplasty on a large scale for valvular stenosis. Their proficiency in successfully instituting this procedure is well recognized in the cardiology world. The physician concurred in the diagnosis and in the proposed therapeutic option. He went on to say that he had a good friend and former roommate who was an invasive cardiologist and chief of the department in a large hospital in Madras. With our approval, he obtained a quick telephone consultation with the cardiologist and arranged for the child to be seen by him the following week at which time evaluation for balloon valvuloplasty would be made. Upon discussion of the cost of the procedure and to our utter surprise, we were quickly offered a significant reduction in price. The physician in some detail expressed his appreciation and that of his cardiologist friend for our visit to their country and our interest and contribution to the welfare of their people. He was cordial and sincere in his comments. He was a kind man.

We returned to the orphanage carrying with excitement our message of hope for the child. The message was sent to her father, a poor farm worker five miles across the mountain.

to come and make arrangements to carry his daughter to Madras.

He arrived the next night to receive the message of hope about his child. After plans had been confirmed for the trip and for payment, we had a brief session of prayer and prepared to retire for the night. The father walked over to me, and I extended my hand to shake his in a gesture of affirmation. He then clasped both of his hands around mine and his deep set eyes now moist with tears caught mine in a connected fixation that penetrated my heart

and soul. In that extended moment the language barrier between us melted as he gently, silently and sincerely said — "thank you."

We have subsequently learned that the valvuloplasty was successful and the child is doing well.

N. B. Baroody, M. D.
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555 E. Cheves Street
Florence, SC 29506-2617

JOIN THE FIGHT AGAINST THE FLU!

Few of us have not been subjected to the discomfort and inconvenience of the flu at some point in time. Perhaps this familiarity has fostered a certain complacency regarding yearly influenza immunizations. However, in any given year, 10,000 to 40,000 deaths in the United States occur as a result of influenza complications. The elderly are vulnerable, particularly those who smoke and those with chronic cardiovascular or pulmonary conditions.

The 1994 data on influenza immunizations (paid claims) for non-HMO Medicare beneficiaries reveals a national immunization rate of 38 percent (U. S. total). The rate for South Carolina is 37 percent, with the rate for Caucasians being 42 percent and for African Americans 22 percent. Total immunizations vary by county, with Calhoun, Clarendon, Florence, and Chester counties having rates of 42 to 45 percent, compared to McCormick, Saluda, Fairfield and Jasper counties, with rates of 14 to 26 percent. Several national surveys indicate that a significant number of Medicare beneficiaries may have received immunizations that were not billed to Medicare.

In 1993, Medicare Part B began paying for influenza immunizations. Recognizing this

potential threat to the Medicare population, the Health Care Financing Administration (HCFA) has launched a national campaign to increase influenza immunizations among beneficiaries. Under the direction of HCFA, Carolina Medical Review (CMR) is working with carriers and public health agencies to coordinate statewide efforts to increase awareness about influenza immunizations among beneficiaries.

CMR is encouraging the medical community to participate in this effort. Brochures and posters on influenza vaccinations are being distributed to hospitals and physician offices. CMR is also helping to coordinate statewide influenza vaccination drives at several senior sites.

For more information on how to get involved in this campaign, please call Diana Zona, CMR Outreach Specialist, at 1-800-922-3089 or (803) 731-8225, extension 203.

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Letters to the Editor

To the Editor:

August 15, 1995 marked the 50th anniversary of the formal end of World War II. In not many years the interest in this war will be similar to the interest that so many have had in the Civil War. Veterans of World War II are dying at a rapid rate, as one can see from obituary pages throughout the country. Soon there will not many of us remaining. I feel that it would be good to leave as much history of the medical profession in South Carolina and our part in World War II as we can leave for future generations.

We are interested in those who served as physicians during World War II, whether in the United States or other countries, particularly those in combat areas; and those who were in the Armed Forces prior to becoming physicians. We would also like some history from nurses and those who served in the women's branches of the Armed Forces (WAC, WAVE, etc.).

So to all of you who served in World War II, please begin thinking about what you were doing more than 50 years ago. Any notes, manuscripts, diaries, etc. that you have will be appreciated. Tape recordings of your experience will be preferable and probably easier, but typed or handwritten notes will be appreciated. Please send to me at the Waring Library, MUSC, 171 Ashley Ave., Charleston, SC 29425.

Charlie, please edit this in any way you wish. I hope all is well with you.

Laurie L. Brown, M. D.
Professor Emeritus
Department of Anesthesiology, MUSC
171 Ashley Avenue
Charleston, SC 29425-2207

To the Editor:

As you know, there are several thousand physicians in South Carolina, both active and retired, who have unpublished stories of their own to tell.

As a suggestion, to put additional life into the journal, you may want to set aside a section entitled "Odds & Ends."

(For example, I formerly practiced in Washington, D. C., and was once told by a former member of the French Foreign Legion that this military unit was not accustomed to carry much in the way of emergency medical equipment; thus they never carried antiseptics such as alcohol, iodine, or mercurochrome. When faced with a severe wound such as compound fracture, it was customary for a companion soldier to urinate on the wound site.)

So you see, even the uneducated can teach us a lesson in antisepsis. There must be hundreds of stories from the rest of us.

John P. Gallagher, M. D.
1488 Village Square
Mount Pleasant, SC 29464

On the Cover:

JAMES ROGERS YOUNG, M. D., 1882-1969 PRESIDENT, SCMA, 1933

The 69th President of the South Carolina Medical Association was born on April 2, 1882, in Due West, South Carolina, where he grew up and attended Erskine College, graduating in 1901. He received his medical education at the Vanderbilt University School of Medicine, earning his M. D. Degree in 1906.

Dr. Young, always eager to improve his knowledge and skill, studied and worked at some of the finest hospitals in Europe before settling in Anderson where he practiced surgery with his brother, Henry, for many years. It is thought that these two surgeons may have performed the first heart and brain surgeries in Anderson in the 1930s (both successful), long before these operations were accepted practice.

Dr. James Young was one of the founders of the Cancer Clinic and gave many hours of free service there to patients who could not afford private care. When it was realized that the Anderson Hospital needed an auditorium, Dr. Young accepted the challenge. Through his own generous donation and his tireless work soliciting other funds, the auditorium was completed and named in his honor.

His achievements in his chosen field are many: Fellow in the American College of Surgeons, Chairman of the S. C. Division of the American Cancer Society (on his retirement from this post in 1968, he was elected

president emeritus) Charter member of the Southeastern Surgical Congress and the Piedmont Post Graduate Assembly.

But medicine was not Young's only interest. He was an active worker in his community, his church and in the progress of his alma mater, Erskine College. He was a Rotarian and, at various times, Chairman of the Chamber of Commerce, a member of the City Council and the School Board.

Dr. Young donated the land for a new Associate Reformed Presbyterian (ARP) church. The congregation named the church in memory of his son who was killed in WW II. Dr. Young served for many years as an elder and was elected Moderator of the South Carolina ARP Synod.

In 1922, Young received the Algernon Sydney Sullivan award for his alumni work for Erskine College, and in 1943, Erskine bestowed on him an LL. D. Degree. He served for many years on the Board of Trustees.

On March 21, 1969, Dr. Young died at the Anderson Hospital where he had devoted much of his life. He was buried from the Young Memorial ARP Church.

Betty Newsom
The Waring Historical Library

Gray Matter

*"Matters of Interest
to South Carolina
Physicians."*

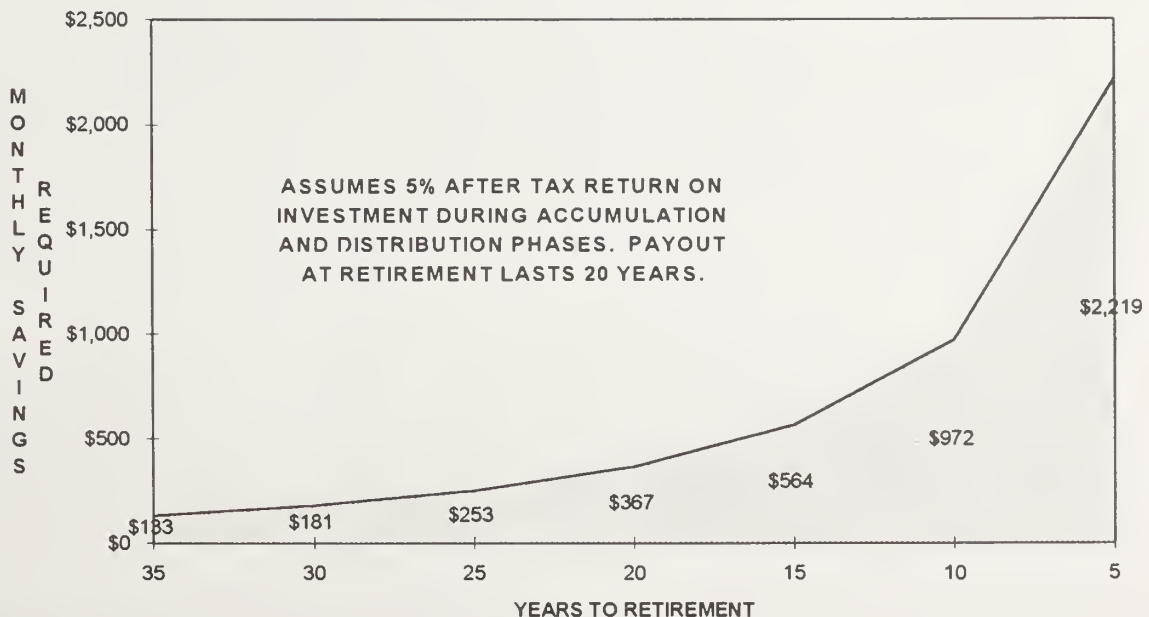
Thornton & Thorne give the medical community something to think about this month.

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B Years to retirement

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D Multiply A x C to get required monthly savings

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Views expressed herein are those of the authors only and in no way represent the SCMA. We do not give tax advice.
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Alliance Page

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Over \$10 million has been raised in the last five years, yet we still have plenty of work ahead of us. In 1991, 42 percent of medical students taking a leave cited financial strain or health as the reason. More than 80 percent of medical school graduates were in debt, the mean dollar amount of debt being \$59,885. It is estimated that an hour of medical education costs \$28 per student.

All contributions to AMA-ERF are 100 percent tax deductible. Each contribution can be assigned to the medical school of choice and to one of these four funds:

- > Medical School Excellence Fund: These are unrestricted funds that have been used to support programs for women and minority medical students; pay for publication subscriptions, computer software and other equipment; and fund student activities, research programs, guest lecturers and student attendance at national meetings and conferences.
- > Medical Student Assistance Fund: These funds provide monies to medical schools to be used for student loans, grants and scholarships. These loans have much lower interest rates than banks.
- > Development Fund: These funds are distributed by the AMA-ERF Board of Directors to support pilot and experimental health and medical programs.
- > Categorical Fund: These funds provide support for specific research areas.

A contribution to AMA-ERF is an investment in medical excellence for our families and for future generations. "THE MEDICAL STUDENT OF TODAY WILL BE OUR PHYSICIAN TOMORROW!" A contribution to AMA-ERF is an investment in the future. Through our continued support, we will continue to make a difference!

Lisa Schroeder (Mrs. Christopher)
SCMAA AMA-ERF Chairperson

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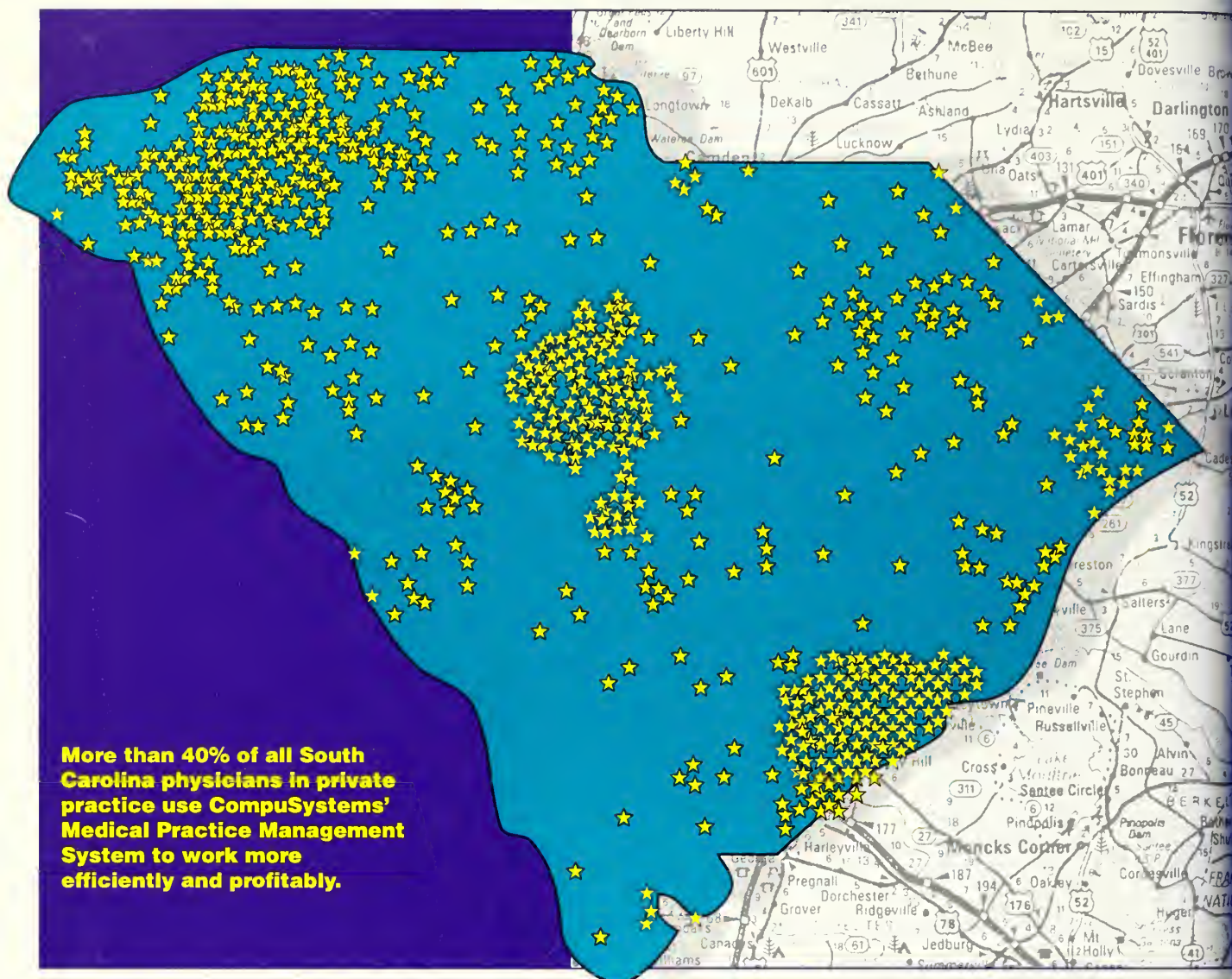
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OF THE SOUTH CAROLINA MEDICAL ASSOCIATION

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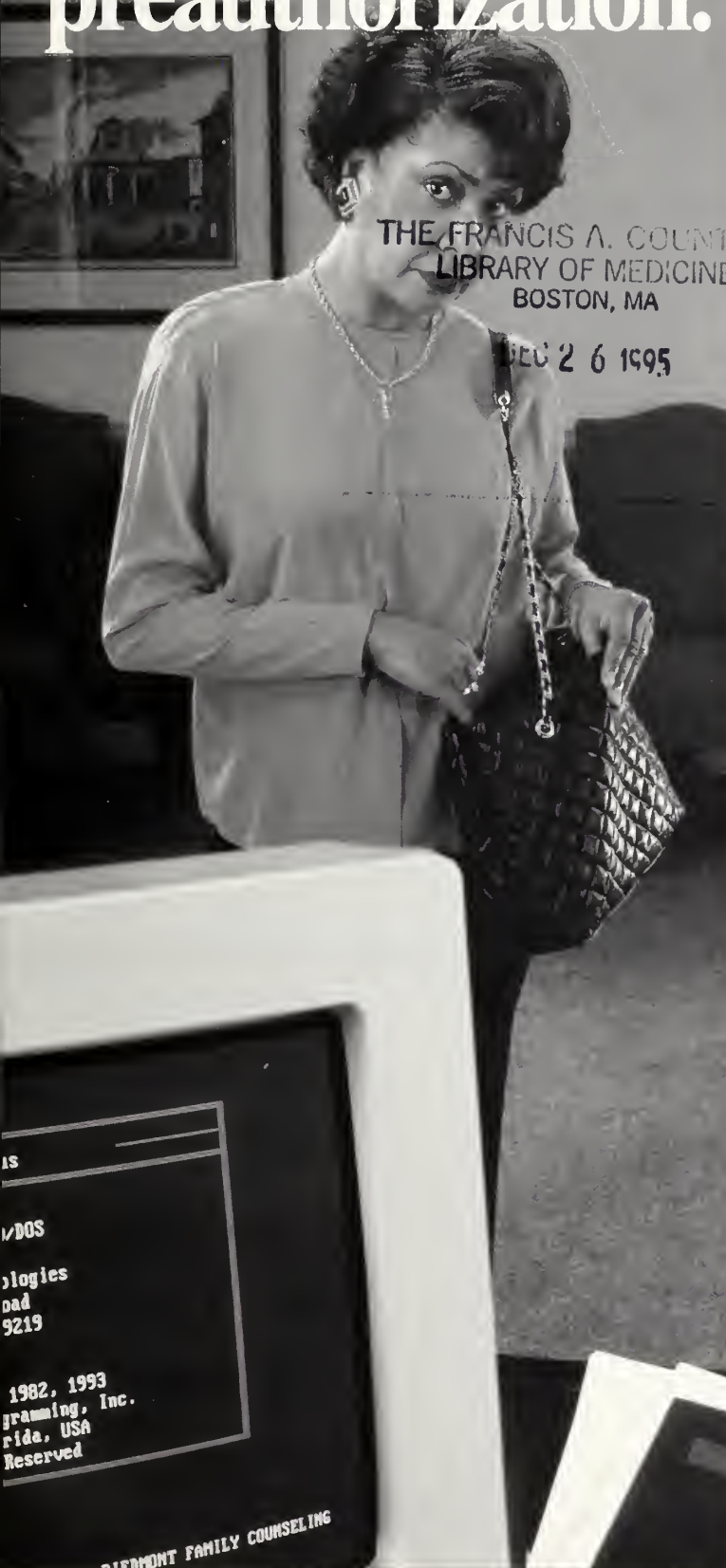
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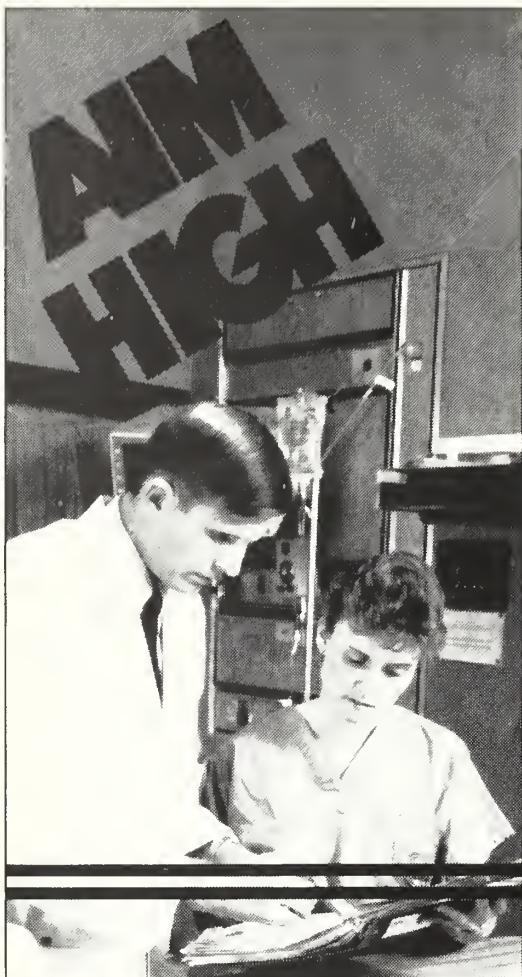
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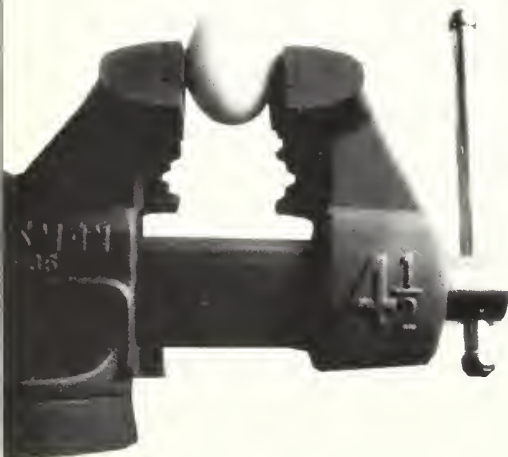
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President's Page

AMA "STUDY OF THE FEDERATION" REPORT

For some time the American Medical Association (AMA), which can be defined as a federation of state medical societies and specialty societies, has been conducting a study on the issue of how to change the AMA in order to maintain its leadership role in organized medicine. The AMA has recently released its study. By the time you read this, there will have been extensive discussions of its recommendations at the AMA interim meeting and possibly approval by the House of Delegates of the study recommendations in some form.

The last reorganization of the AMA was in 1901 when it was an all white, male organization composed of general practitioners and surgeons, all in solo practice. Today, the AMA is composed of men and women of many different ethnic distinctions and specialties. Their practices may be solo or group and payment may be fee for service, salary, managed care, or capitation. It is obvious that the AMA needs to change in order to respond to the needs of today's physicians and to be a relevant presence in the future.

The AMA wants to be a true umbrella organization for all medical organizations and it will have to work closely with these organizations in order to do so. This does not mean, however, that the Federation will be able to impose solutions on any individual component: demonstration of mutual benefit will be essential.

The study which the AMA has conducted recommends a change in the composition of the House of Delegates to reflect the four major dimensions of a physician's life:

- geographic location
- specialty
- mode of practice
- demographic/career stage/ethnic cultural

Currently, the House of Delegate is composed of 79 percent state delegates, 19 percent specialty delegates, and two percent mode of practice and ethnic cultural. After a three year phase-in, it is recommended that composition be 58 percent state delegates, 36 percent specialty delegates, and six percent mode of practice and ethnic cultural. Under this plan, South Carolina will lose one delegate, leaving us with three delegates. The study also recommends that the Board of Trustees add two members in order to increase the diversity of the board.

I believe that these proposals are excellent and that they *can* be done. State delegates and board members will be listening to the debate in the AMA House of Delegates this month. What is decided in these meetings will present a challenge to the South Carolina Medical Association (SCMA). We will have to study our own organizational structure and propose changes in our House of Delegates and Board of Trustees which will be consistent with AMA changes and also better represent the changing demographics of our own state. I hope that the changes we decide upon will answer the concerns that some of you have expressed to me about your specialties' representation in SCMA, and also that they will put SCMA on a firmer basis to meet the challenges which the future is sure to bring.

Benjamin E. Nicholson, M. D.
President

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SCMA NEWSLETTER

A PUBLICATION OF THE SOUTH CAROLINA MEDICAL ASSOCIATION

Joy Drennen, Editor

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December 1995

HIGHLIGHTS OF NOVEMBER 15 BOARD OF TRUSTEES MEETING

President Benjamin E. Nicholson, MD, reported that the SCMA had received from the Committee on Review and Recognition of the ACCME an additional four years' recognition as the CME intrastate accreditor of institutions in South Carolina.

Chairman of the Board S. Nelson Weston, MD, reported on discussions with the South Carolina Hospital Association regarding a joint network to provide health care for Medicaid patients. These discussions will continue

and SCMA members will be kept informed.

Board members voted to support legislation that would establish a statewide, population-based cancer registry at DHEC under a grant from the Centers for Disease Control.

The Board also voted to support a model policy for hospitals regarding advance health care planning directives.



MEDICARE UPDATE

The December, 1995 *Medicare Advisory* contains important information for you and your staff. This month, the Advisory includes a Medigap update, lists certified mammography screening facilities, services in the monthly capitated payment for maintenance dialysis, billing tips for office practices in hospital settings, new clinical lab codes, and much more. Following are a few highlights from the December, 1995 *Medicare Advisory*.

Influenza Vaccine Allowed Amount Update: Medicare will adjust all claims where the influenza vaccine code (CPT code 90724) was reimbursed at the \$3.38 rate. The claims should have been paid at the \$4.38 rate effective on or after July 12, 1995. Please do not resubmit these claims. Please allow Medicare 45 days to process these adjustments. *If you do not receive a remittance advice showing an adjustment by January 15, 1996, please call the Medicare Part B Provider Service Center at (803) 788-5568.*

1996 Fee Schedule Corrections: The Health Care Financing Administration (HCFA) has issued three corrections to the 1996 fee schedule which was mailed to all providers on November 15, 1995. Please make note of these changes in your 1996 Enrollment Packages and Fee Schedule Bulletin.

<u>Code</u>	<u>Participating Fee</u>	<u>Nonparticipating Fee</u>	<u>Limiting Charge</u>
22840	484.44	459.27	528.17
22842	554.41	526.41	605.38
22845	460.88	437.84	503.52

(continued on page 2)

MEDICARE UPDATE (continued)

1996 Medicare Program Changes and Update Workshops: Medicare has scheduled eight workshops throughout SC to discuss the following issues: changes to the Medicare program for 1996, revised Medicare remittance notice, new correct coding combinations, rejecting processable claims, other Carrier Names and Addresses (OCNA), electronic media claims, the Participation Program and other pertinent information. *Please call the Medicare Part B Provider Service Center at (803) 788-5568 for more information.* The dates and times for the workshops are noted below:

Greenville, December 12, 9 am-12noon
Columbia: December 14, 9 am - 12 noon
Spartanburg: December 19, 9 am-12 noon
Aiken: December 21, 9 am-12 noon

Florence: December 13, 9 am-12 noon
Myrtle Beach: December 15, 9 am-12 noon
Charleston: December 20, 9 am-12 pm
Anderson: December 22, 9 am-12 noon

Certifications of Medical Necessity: Federal law, as amended in 1994, restricts information that suppliers may provide to physicians in Certifications of Medical Necessity (CMNs) and requires suppliers to include relevant charge information for items and services they list on CMNs. These amendments supersede those of the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990). Please refer to the December, 1995 *Medicare Advisory* for specific requirements and provisions of the law. □

MEDICAID UPDATE

ICD-9 CM Diagnosis Code Updates: As a reminder, effective January 1, 1996, only the 1995 ICD-9 diagnosis codes will be accepted.

Medicare/Medicaid Electronic Crossovers: A computer problem has been identified with the processing of Medicare/Medicaid electronic crossover claims. The processing of electronic crossover claims has been delayed temporarily pending correction of the problem. It is anticipated that the crossover claims will be processed for payment in your December 8, 1995, remittance advice.

If your office staff has received any edit correction forms with edit 634 (deductible amount is greater than the net claim charge), please have your staff contact their program manager at (803) 253-6134 for instructions on correcting this edit. DHHS apologizes for any confusion or problems this has caused your office.

Surgical Modifiers: Current SC Medicaid policy requests that all surgical procedure codes for the same patient on the same date of service be filed on the same claim form. This ensures that the correct procedure will reimburse at 100 percent of the Medicaid established rate and all second or subsequent surgical codes will reimburse at 50 percent (with a few exceptions) of the Medicaid established rate.

At times, however, surgical codes are filed on separate claim forms. In the past, this may have caused incorrect payments and the need for manual adjustments. In an effort to streamline Medicaid surgery payments, effective with claims processed on or after November 28, 1995, surgery adjustments (when applicable) will be automatically calculated and reflected in the second claim processed. The automated adjustment process should reduce turnaround time and ensure accurate payments. Please refer to the October 25, 1995, Medicaid Bulletin for details and information concerning the updated methodology for surgical payments. Please contact the appropriate program manager at (803) 253-6134 if you or your staff have any further questions regarding the bulletin.

Billing Workshop: The Department of Physician Services will offer their next basic billing workshop on February 1, 1996, at 12:30 pm. The workshops are designed for new billing staff and new providers in the SC Medicaid Program. The workshop will be held in the Jefferson Square Plaza at 1801 Main Street in the second floor training room. Due to limited training space, reservations are required. Please contact your program manager at (803) 253-6134 to reserve a space. The basic billing workshops are offered free on a quarterly basis. □

CHAMPUS UPDATE

CHAMPUS requires that providers obtain preauthorization for the following procedures when performed on an inpatient basis: abortion, hysterectomy and cesarean section.

OB/GYNs and family practitioners providing OB/GYN services to CHAMPUS beneficiaries should be particularly aware of this requirement, which has been in effect since May, 1992.

In SC, preauthorization of these cases is obtained by calling PRO-West, a professional review organization, at (800) 783-2477. Phones are staffed Monday-Friday from 5:00 am to 5:00 pm (PT). When all lines are busy or when staff are not available, leave a voice mail message. Or, you may fax your preauthorization request to (800) 431-2565. Authorization must be obtained not more than 30 days and not less than two working days prior to the admission/procedure. If the admission/surgery is urgent or emergent, providers have up to two working days after the admission/procedure to obtain authorization.

TELEVISION VIOLENCE TARGETED

Last month, the South Carolina Medical Association (SCMA) and the South Carolina Attorney General's Office held a press conference, announcing the "Unplug the Violence" campaign. The SCMA is pleased about this partnership because of the opportunity to expand our campaign against violence one step further to include media violence. Dr. Benjamin Nicholson, SCMA president, cited statistics that children are exposed to 200,000 acts of violence in the media by the time they graduate from high school.

The "Unplug the Violence" campaign begins with the distribution of brochures, outlining tips for parents to pull the plug on media violence. Physicians are encouraged to display these brochures in their offices. *If you are interested in receiving these brochures for your office, please call Audria Belton at (803) 798-6207, ext. 234, or 1-800-327-1021 statewide.* ☐

REMINDER: TAX ID NUMBER

Please remember the importance of reporting your tax identification number to third party payors. As you know, each third party payor is responsible for providing a 1099 tax form annually. If a third party payor has incorrect tax ID information, this will delay your ability to file your taxes. Additionally, many payors identify providers by tax ID. An incorrect ID number can cause a delay in your claims being processed, which ultimately affects reimbursement. Please make sure that the payors with whom you do business have the most current, accurate information concerning your practice.

PHYSICIANS CARE NETWORK UPDATE

Hampton General Hospital in Varnville has joined the PCN effective December 1, 1995.

If you have questions or would like information regarding the PCN, please call Barbara Whittaker or Cindy Osborn at the SCMA.

UPDATE: SCMA WORKSHOPS

You should have received information about the SCMA Coding Seminar Series to be held January 15-18 and February 5-8, 1996, 9:00 am-4:00 pm. Basic and advanced courses are offered during a week-long series in Columbia and Charleston as follows:

Sheraton Hotel and Conference Center, Columbia

CPT Coding for Doctors' Offices – January 15
ICD-9 CM Coding for Doctors' Offices – January 16
Advanced CPT Coding – January 17
Advanced ICD-9-CM Coding – January 18

Radisson Inn Charleston Airport, Charleston

CPT Coding for Doctors' Offices – February 5
ICD-9-CM Coding for Doctors' Offices – February 6
Advanced CPT Coding – February 7
Advanced ICD-9-CM Coding – February 8

Brochures describing two workshops entitled, *"Developing a Capitation Rate,"* will be mailed to your office prior to December 31, 1995. Two different half-day workshops, providing for specialty care and for primary care practices, will be offered at the Holiday Inn Express on St. Andrews Road in Columbia. The specialty care workshop will be held from 9:00 am until noon, and the primary care workshop will be held from 2:00 to 5:00 pm.

For information regarding any of the workshops described above, contact Ginny Comer at the SCMA, extension 253, 798-6207 in Columbia, or 1-800-327-1021 statewide.

! BULLETIN !

As this Newsletter goes to press, Randolph D. Smoak, Jr., MD, Orangeburg, SC, has been elected Secretary-Treasurer of the AMA Board of Trustees.

Several vacancies in AMA officer positions were created when John P. Seward, MD, was named the new AMA Executive Vice President, replacing James S. Todd, MD, in early 1996.

MARK YOUR CALENDARS

SCMA ANNUAL MEETING, 1996

APRIL 25-28, 1996

THE CHARLESTON PLACE HOTEL (Formerly the Omni)



STEREOTACTIC CORE BIOPSY OF NONPALPABLE BREAST LESIONS*

J. W. STRONG, M. D.

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R. M. AUSTIN, M. D.**

F. H. GRUBER, M. D.

M. N. BAGG, M. D.

Breast cancer is the second leading cause of cancer deaths in women in the United States; approximately one of eight women will develop breast cancer during her lifetime.¹ With the increasing use of mammographic screening and the improvement of radiographic quality during the past decade, detection of suspicious, nonpalpable breast lesions has greatly increased. However, mammographic appearances are not entirely specific for cancer, and the positive rate for breast biopsies performed for mammographically detected nonpalpable abnormalities is low, ranging from 11 to 36 percent.² In fact, some investigators maintain that an aggressive screening program should yield a positive biopsy in no more than 10 percent of cases.³ Additionally, a recent study showed that failure to diagnose breast cancer was the second

most frequent reason for claims brought against physicians, and the most expensive.⁴

Surgical excision is currently the most common technique of breast biopsy, but it is expensive, labor intensive, and relatively traumatic. The preceding facts and current trends in health care mandate development of less costly, less traumatic methods of investigating nonpalpable lesions.

Although stereotactically guided fine needle aspiration may successfully achieve these goals in selected patients, the interpretive expertise required and limitations of this procedure are well known to pathologists and many surgeons. Another alternative is the use of stereotactic core breast biopsy (SCBB), which has received increasing attention in recent medical literature. We report our experience with the use of stereotactic core breast biopsies for mammographically suspicious, nonpalpable breast lesions in a 350-bed private community hospital.

MATERIALS AND METHODS

Ninety-seven patients, ages 29 to 94 (mean

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age 57.3 years) with mammographically detected, asymptomatic, nonpalpable breast lesions underwent SCBB following the recommendation of radiologists (F. H. G. and M. N. B.) and their physicians. They otherwise would have undergone open surgical biopsy. The procedure was performed with a Mam-motest® stereotactic device (prone patient) and a long-throw (2.3 cm.) Biopsy® gun using a 14-gauge Manan needle. A mean of 5.0 cores was taken from each lesion. Lesions were mammographically categorized by suspicion (high, >60% chance of malignancy; intermediate, 25-60%; low, <25%) and according to lesion character (well-defined/smooth mass, indistinct mass, spiculated mass, asymmetric density, and clustered microcalcifications [CM]).

Biopsy specimens were fixed in 10 percent neutral buffered formalin, processed routinely, and stained with hematoxylin and eosin.

RESULTS

Histologic and radiographic findings were correlated at the time of biopsy and again retrospectively, using follow-up mammographic or biopsy data when available, to ascertain sampling accuracy. There was 92 percent correlation, with eight percent partial or non-correlation. Of the latter, five of eight lesions represented CM not seen in the histologic samples. In one of these cases, however, calcifications were seen in a radiograph of the core specimens. The other three were cysts (they disappeared immediately following biopsy) which had been biopsied secondary to equivocal pre-biopsy ultrasound. No definite cyst lining was identified within the histologic material, however, and the cases were therefore classified as partial correlates (i.e., partial correlation was assigned to those cases in which evidence of lesion sampling existed, but the evidence was non-histologic).

The 97 sampled lesions radiographically ranged from 0.4 – 3.5 cm. in maximal dimension. Of these, 72 (74%) had been radiographically categorized as low suspicion, 10 (10%) as intermediate, and 15 (16%) as high.

Fourteen of 25 intermediate and high suspicion lesions were spiculated masses, five were CM, and five were indistinct masses. Fifteen infiltrating carcinomas were identified, of which 10 were mammographically highly suspicious, three were intermediate, and two were low (Tables 1–3.) No in-situ carcinomas were identified in this series.

In eight cases of benign disease (8%), open surgical biopsy was performed subsequent to SCBB, thus adding a procedure to the diagnostic protocol for these patients. As illustrated in Tables 4 and 5, these cases represented a range of mammographic characters and categories. Six of the eight cases occurred during the first 23 stereotactic biopsies at our institution, suggesting that physician confidence in the procedure increased during the trial. Conversely, 74 women (76%) were spared open surgical biopsy by the SCBB procedure. Since all 15 women with carcinoma went to mastectomy without an intervening open biopsy, SCBB did not add a diagnostic procedure for these women.

A simple analysis of standard charges for open surgical biopsy performed on an outpatient basis in our region showed substantial savings for the usual patient who underwent SCBB, and for our series of patients, despite the added diagnostic procedure for eight women (Figure 1.) For instance, the charge for an outpatient open surgical biopsy with needle localization, frozen section, radiograph of specimen, and five to 10 paraffin blocks would be \$3,131.00 to \$3,188.00. The charge for SCBB with five passes and one paraffin block would be \$962.00, a savings of \$2,169.00 to \$2,226.00 (69–70%). If one assumes that all patients in our study who underwent SCBB would otherwise have gone to open surgical biopsy, the procedure resulted in a total approximate charge reduction between \$169,700.00 and \$190,400.00 (59–62%), taking into account the eight additional diagnostic procedures.

In addition to the previously described diagnoses, other diagnoses by SCBB in our series included one reactive lymph node, one

Table 1 Risk Categories and Characterizations

	Smooth/ Well-de- fined Mass	Indistinct Mass	Spiculated Mass	Clustered Microcalci- fications	Asymmetric Density	Unspecified	Total
Low Suspicion	25	31	5	7	2	2	72
Intermediate Suspicion	1	3	2	4	0	0	10
High Suspicion	0	2	12	1	0	0	15
Total	26	36	19	12	2	2	97

Table 2 Diagnoses: Carcinomas and Atypical Hyperplasias

	Smooth/ Well-defined Mass	Indistinct Mass	Spiculated Mass	Clustered Microcalci- fications	Asymmetric Density	Unspecified	Total
Infiltrating Duct Ca.	1	1	10	0	0	0	12
Infiltrating Lobular Ca.	0	1	1	0	0	0	2
Neuroendo- crine Ca.	0	1	0	0	0	0	1
ADH	1	0	0	0	0	0	1
ALH	0	1	0	0	0	0	1
Total	2	4	11	0	0	0	17

Table 3 Diagnoses: Carcinomas and Atypical Hyperplasias

	Low Suspicion	Intermediate Suspicion	High Suspicion	Total
Infiltrating Duct Ca.	1	2	9	12
Infiltrating Lob. Ca.	1	0	1	2
Neuroendocrine Ca.	0	1	0	1
ADH	1	0	0	1
ALH	1	0	0	1
Total	4	3	10	17

BREAST BIOPSY

Table 4 Follow-up Procedures

Subsequent Procedure	Smooth/Well-defined Mass	Indistinct Mass	Spiculated Mass	Clustered Microcalcifications	Asymmetric Density	Unspecified	Total
None	23	31	6	10	2	2	74
Open Surgical Bx	2	2	2	2	0	0	8
Mastectomy	1	3	11	0	0	0	15
Total	26	36	19	12	2	2	97

Table 5 Follow-up Procedures

Subsequent Procedure	Low Suspicion	Intermediate Suspicion	High Suspicion	Total
None	65	6	3	74
Open Surgical Bx	5	1	2	8
Mastectomy	2	3	10	15
Total	72	10	15	97

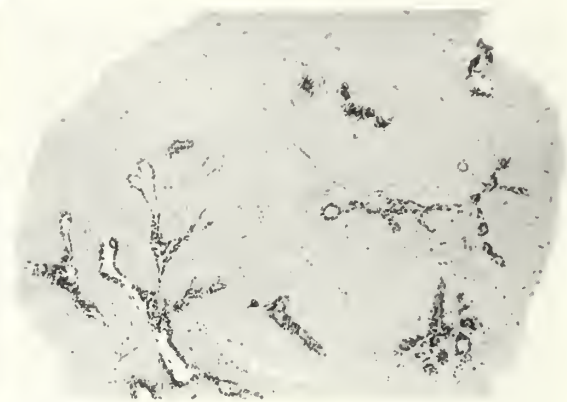


Figure 1 (A) Well-defined mass, generally a low-risk lesion. (B) Corresponding fibroadenoma.

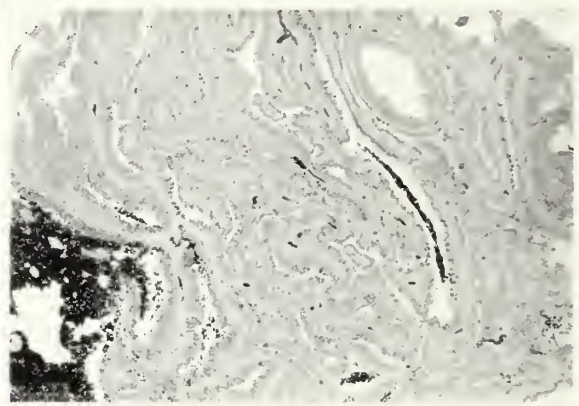


Figure 2 (A) Indistinct mass. Focally, the edges of the lesion blend with surrounding parenchyma. (B) In this case the lesion was an intraductal papilloma.

intraductal papilloma, one collagenous spherulosis, one membranous fat necrosis, and numerous cases of fibrocystic change and fibroadenoma. Complications included several hematomas and fainting in one woman. There were no false positive or negative cases among those who had an additional procedure or follow-up.

CONCLUSIONS

The increasingly abundant use of mammography for breast cancer screening has resulted in increased detection of small, good prognosis, invasive cancers. According to Tabar et al.,⁵ survival for tumors less than 10 mm. approaches 100 percent, and their data show that for these small tumors, long-term sur-

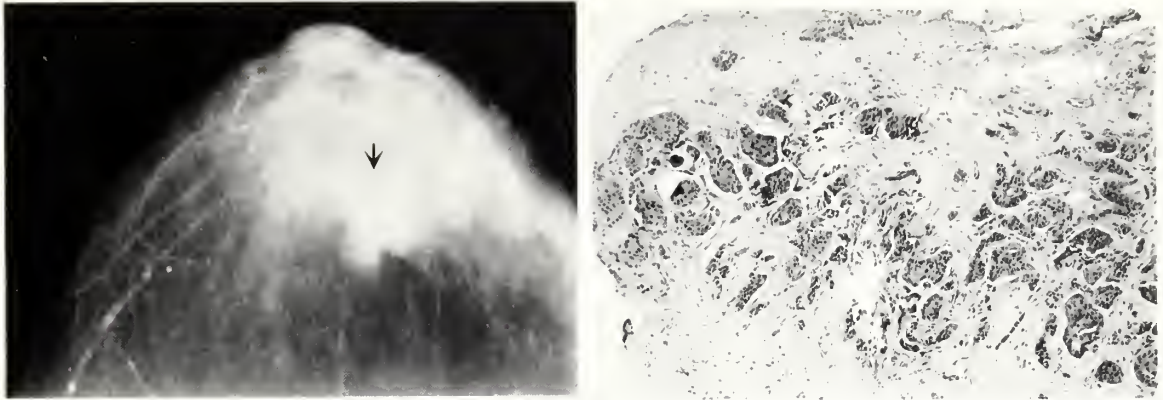


Figure 3 (A) Spiculated mass, usually regarded as a high-risk lesion. (B) Corresponding grade III/III apocrine carcinoma.

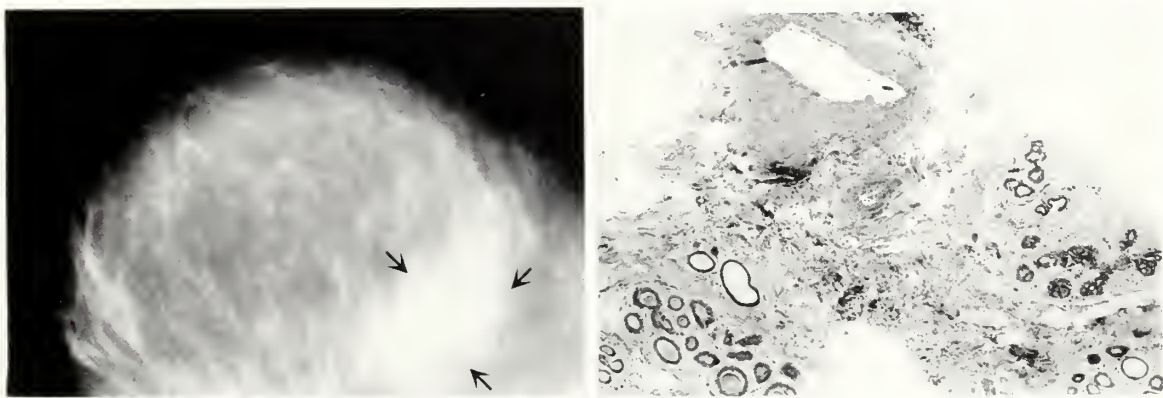


Figure 4 (A) Asymmetric density. (B) Fibrocystic change.

vival is good regardless of tumor grade. Modern screen-film mammography can reliably detect these very small invasive breast cancers (particularly for women > 50 years old), but the radiographic features of carcinoma are generally nonspecific, forcing radiologists to quantify suspicion based on individual lesion characteristics and recommend follow-up accordingly. Approximately two percent of women undergoing mammographic screening are recommended for biopsy,⁶ but only approximately 10 to 40 percent of biopsies in the United States for mammographic abnormalities reveal malignancies.^{2,6} For mammography to be optimally reliable and cost effective, a positive biopsy yield for mammographically initiated biopsies between 10 and 30 percent has previously been considered acceptable,^{3,7} but physicians, patients, and third parties are increasingly concerned about the number of benign biopsies performed.

In this study of 97 women who underwent SCBB for mammographically suspicious nonpalpable lesions, 74 women (76%) were spared from open surgical biopsy. Among these were 90 percent of women with lesions of low mammographic suspicion (65 of 72) and 36 percent of women with intermediate and highly suspicious lesions (nine of 25). Fifteen women with carcinoma went to mastectomy without an intervening biopsy; therefore, SCBB did not add a diagnostic procedure for these women. Eight of the women in the study (8%) went to open surgical biopsy following SCBB, resulting in an added procedure in the diagnostic/therapeutic protocol. Five of these eight women had lesions previously designated "low suspicion" by mammography. However, six of the eight cases occurred during the first 23 SCBBs performed in our institution, and we believe that early lack of confidence by clinicians in the

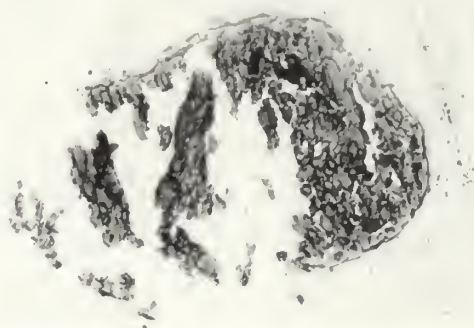


Figure 5 (A) Clustered microcalcifications. These were pleomorphic, of intermediate suspicion. (B) Biopsied material was benign, predominantly stroma, with prominent calcifications.

new procedure factored into the additional open biopsies, which confirmed the SCBB results.

There were no false positive or negative cases among the SCBB patients of this series who had an additional procedure of follow-up. However, one false negative occurred in a patient who underwent SCBB shortly following this study. The patient underwent SCBB for a 1.0 cm. indistinct mass. However, the lesion became obscured during the procedure by hemorrhage, and the radiologist noted in his report that the lesion may not have been sampled. Histology showed duct epithelial hyperplasia without atypia, as well as portions of a small muscular artery. Her mammographic abnormality persisted, and seven months later she was found at open surgical biopsy to have a 0.9 cm. diameter low-grade infiltrating duct carcinoma with extensive associated intraductal carcinoma.

An impressive but not unexpected finding of this study was the degree of reduced charges for SCBB as compared to open surgical biopsy. Typical charges for an open surgical procedure in our institution were up to \$3,188.00, whereas the typical charge for SCBB with five needle passes might be as low as \$962.00, a potential savings of 69–70 percent. The cumulative reduction of charge for the study patients remained notable after taking into account those patients for whom SCBB resulted in an additional diagnostic/therapeutic procedure (59–62 percent sav-

ings overall).

Reported complications of SCBB have included hematomas, vasovagal reactions, local cellulitis, and minor oozing of blood from the site of needle insertion.⁸⁻¹¹ Complications in our study included only several small hematomas and a vasovagal reaction in one patient. There were no serious immediate complications for the women in this study. The number of vasovagal reactions can apparently be reduced by using a dedicated stereotactic unit that allows the patient to remain prone during the procedure,⁹ like the device used for our study. Parker maintains that "the breast is the one area of the body where it is virtually impossible to harm the patient with a needle biopsy, regardless of its gauge."¹² He and his colleagues have obtained as many as 15 or more biopsy specimens from one area of the breast without adverse effect. They also report that in over 3,765 cases, only six patients (0.2%) developed clinically significant complications which included three hematomas and three infections.¹³ Other limitations of SCBB exist, however. For example, the excursion of long-throw automated biopsy guns may be too long to avoid hitting the back plate of the compression apparatus when biopsying small breasts.⁶ This is generally not a serious complication, and many of the stereotactic devices on the market today warn the operator prior to such an occurrence.⁸ Also, sampling of superficial lesions with SCBB may

require that the needle-throw start outside the breast,⁶ which may hinder accurate sampling of a lesion. Along the same line of reasoning, making a small skin incision prior to any SCBB procedure increases sampling accuracy by minimizing the friction encountered by the needle as it passes through the skin and subcutaneous tissues.^{11,12}

Youngson et al.¹⁴ have recently reported finding displaced epithelial cells in 31 surgical breast biopsy specimens, 29 of which were retrospectively determined to have recently been subjected to a needling procedure. The findings included displaced epithelial fragments, either in the fibrous breast stroma or fat adjacent to or within the needle track, or in lymphovascular channels. In one case with intraductal carcinoma at the margin and intralymphatic tumor emboli, subsequent reexcision and axillary dissection confirmed the intraductal nature of the lesion but showed clusters of carcinoma cells in the subcapsular sinuses in two of 10 axillary nodes. Although the authors' implications are clear, circumspect interpretation of this data is warranted. The authors conclude that displacement of detached epithelial fragments during needling procedures is conceivable and that perhaps these fragments may even travel to lymph nodes in lymphovascular channels, but the viability and metastatic potential of these fragments remains unclear.

In a multi-institutional study involving a consortium of 20 institutions using percutaneous large-core breast biopsies utilizing dedicated stereotactic devices or high-frequency electronically focused ultrasound equipment for needle guidance, Parker et al. recently reported their experience.¹³ The study included 6,152 lesions sampled with core breast biopsy, and clinical or surgical follow-up was obtained for 3,765 lesions. Among those with surgical follow-up, complete agreement between core biopsy and surgical biopsy diagnoses was achieved in 1,223 (89%), partial agreement in 125 (9.2%), and disagreement in 15 (1.1%). The disagreements were mitigated by the finding that eight of the 15

"misses" occurred in lesions characterized as microcalcifications without a mass, which generally represent cancers in the earliest stages, perhaps reducing the prognostic impact of an early miss. The authors conclude that "percutaneous large core biopsy is as successful as diagnostic surgical excisional biopsy in the correct histologic diagnosis of a lesion."¹³

When using large core needles (14g) with a long excursion (2.3 cm.), Liberman et al.¹⁵ found that diagnostic material could be obtained with a single pass in 70 percent of lesions. With five cores, they obtained diagnostic material in 94 percent of lesions (including 99 percent of mass lesions and 87 percent of CM). For standard protocol they suggest that a minimum of five cores be taken from all lesions, and they require additional cores from CM if no calcifications are seen in specimen radiographs.

Based upon our own experience with SCBB and the experience of others reported in the literature, SCBB offers many advantages over fine needle aspiration or open surgical biopsy for nonpalpable lesions. Since actual tissue cores are obtained with the procedure, general pathologists without cytopathologic expertise can more confidently interpret the results. Also, the inability of cytology to diagnose invasion, its relatively low specificity in benign diagnoses, and the false-negative results associated with FNA can largely be avoided with SCBB. As compared to open surgical biopsy, the minimal invasiveness, paucity of clinically significant complications, and reduced cost of SCBB have already been discussed. In addition, SCBB generally leaves no skin scar or persistent mammographic changes ("pseudolesions") which may hinder future mammographic examinations.^{6,11,13,16} Although we agree that any atypia on SCBB should be followed by a surgical biopsy,⁶ we believe that SCBB is a viable, accurate, cost-effective, and minimally traumatic means of investigating mammographically suspicious nonpalpable breast lesions.

SUMMARY

We report our experience with stereotactic core breast biopsies (SCBB) for mammographically suspicious, nonpalpable breast lesions. Ninety-seven patients, ages 29 to 94 (mean 57.3 years) underwent SCBB with a 14-gauge Biopsy[®] gun. A mean of 5.0 cores was taken from each lesion. Lesions were mammographically categorized by suspicion (high, > 60% chance of malignancy; intermediate, 25–60%; low, < 25%) and according to lesion character (well-defined mass, indistinct mass, spiculated mass, asymmetric density, and clustered microcalcifications [CM]). Histologic and radiographic findings were correlated at the time of biopsy and again retrospectively, with 92 percent correlation and eight percent partial or non-correlation. Of the latter, five of eight lesions represented CM not seen in the histologic samples. Of the 97 sampled lesions, 72 (74%) had been radiographically categorized as low suspicion, 10 (10%) as intermediate, and 15 (16%) as high. The procedure saved 74 women (76%) from open biopsy and added a diagnostic procedure for eight women (8%). Fifteen women (15%) went directly to mastectomy; therefore, the SCBB neither added nor saved a procedure for patients with cancer. Of the 72 lesions categorized as low suspicion, 65 (90%) were potentially saved from open biopsy, while nine of 25 lesions (36%) in the intermediate and highly suspicious groups were potentially spared a procedure. There were no false positive or negative cases among those who had an additional procedure or follow-up. The diagnoses made on SCBB included 15 carcinomas, one case each of atypical ductal and atypical lobular hyperplasia, one reactive lymph node, one intraductal papilloma, one collagenous spherulosis, one membranous fat necrosis, and numerous cases of fibrocystic change and fibroadenoma. In conclusion, we believe that this SCBB method can be an accurate and cost-effective tool in the management of these lesions. □

REFERENCES

1. Fletcher SW, Black W, et al. Report of the International Workshop on Screening for Breast Cancer, Bethesda, Maryland. Sponsored by the National Cancer Institute, 1993.
2. Fajardo LL, Davis JR, et al. Mammography-guided stereotactic fine-needle aspiration cytology of nonpalpable breast lesions: Prospective comparison with surgical biopsy results. *American Journal of Radiology*, 155: 977-981, 1990.
3. Hall FH. Screening mammography – Potential problems on the horizon (letter). *NEJM*, 314(1): 53-55, 1986.
4. Donegan WL. Evaluation of a palpable breast mass. *NEJM*, 327(13): 937-942, 1992.
5. Tabar L, Fagerberg G, Duffy SW, et al. Update of the Swedish two-county Program of Mammographic screening for breast cancer. *Radiologic Clinics of North America*, 30(1): 187-210, 1992.
6. Schmidt RA. Stereotactic breast biopsy. *CA – A Cancer Journal for Clinicians*, 44(3): 172-191, 1994.
7. Goedde TA, Frykberg ER, Crump JM, et al. The impact of mammography on breast biopsy. *The American Surgeon*, 58(11): 661-666, 1992.
8. Parker SH, Lovin JD, Jobe WE, et al. Stereotactic breast biopsy with a biopsy gun. *Radiology*, 176(3): 741-747, 1990.
9. Parker SH, Lovin JD, Jobe WE, et al. Nonpalpable breast lesions: Stereotactic automated large-core biopsies. *Radiology*, 180(2): 403-407, 1991.
10. Dowlathshahi K, Yaremko ML, Kuskens LF, Jokich PM. Nonpalpable breast lesions: Findings of stereotactic needle-core biopsy and fine-needle aspiration cytology. *Radiology*, 181(3): 745-750, 1991.
11. Burbank F, Belville J. Core breast biopsy, research and what not to do. *Radiology*, 185(3): 639-640, 1992.
12. Parker SH. When is core biopsy really core? *Radiology*, 185(3): 641-642, 1992.
13. Parker SH, Burbank F, Jackman RJ, et al. Percutaneous large-core breast biopsy: A multi-institutional study. *Radiology*, 193(2): 359-364, 1994.
14. Youngson BJ, Cranor M, and Rosen PP. Epithelial displacement in surgical breast specimens following needling procedures. *American Journal of Surgical Pathology*, 18(9): 896-903, 1994.
15. Liberman L, Dershaw DD, Rosen PP, et al. Stereotactic 14-gauge breast biopsy: How many core biopsy specimens are needed? *Radiology*, 192(3): 793-795, 1994.
16. Kaye MD, Vicinanza-Adami CA, Sullivan ML. Mammographic findings after stereotactic biopsy of the breast performed with large-core needles. *Radiology*, 192(1): 149-151, 1994.

DISCOID MENISCUS IN A FOUR-YEAR-OLD CHILD

RICHARD S. MCCAIN, M. D.*

A four-year-old black female was seen in the office with primary complaints of popping with discomfort in her right knee for the past year. This was associated with a slight limp. She denied fever. There was no family history of knee problems.

Physical exam revealed repetitive clunking of the knee in extension. There was popping over the lateral joint line. Mild effusion was noted. Collateral ligaments were stable. Lachman and posterior drawer at 90 were negative. Patellar tendon and quadriceps tendon were nontender. Patella glide was 2+, patella tilt was 1+, and there was no significant tenderness in the patellofemoral joint. X-rays including AP and Lateral of the knee were negative. The impression was rule out discoid meniscus and an MRI scan was requested. The MRI report revealed normal medial meniscus. There was abnormal increased signal throughout the lateral meniscus and the meniscal tissue was thicker and more medially located than is the norm. No definite Grade III tears were identified, but there were diffuse Grade II changes throughout the entire lateral meniscus (Figure 1).

Arthroscopy and mini-arthrotomy were performed under general anesthesia using small 2.7 instruments. Prior to prepping and draping but with the patient asleep, the knee was put through a range of motion, again confirming subluxation of the discoid meniscus on near extension of the knee producing an audible clunk or pop.

A tourniquet was applied to the knee, as well as a surgical knee assistant holder, and the knee was prepped and draped. Routine arthroscopy portals were made. The scope was introduced through the anteromedial por-



Figure 1. MRI coronal view right knee with discoid lateral meniscus to left.

tal visualizing the lateral knee joint. The lateral meniscus was probed throughout its anterior, lateral, and posterior horns and found to be without tear. There was adequate attachment throughout the periphery of the meniscus on both surfaces without defect. The popliteus tendon was identified. The lateral meniscus was discoid and did not have the typical half-moon shaped appearance. In addition the lateral meniscus was much thicker than normal. The remainder of the joint inspection was normal (Figures 2 and 3).

Using the small joint arthroscopy instruments, a portion of the discoid meniscus was excised (Figure 4). After this initial trimming of the meniscus, the instruments were removed and the knee was put through a range of motion with persistence of the clunking. A mini lateral arthrotomy was performed. Kocher clamps (small), and a disposable fish-mouth arthroscopy blade were used

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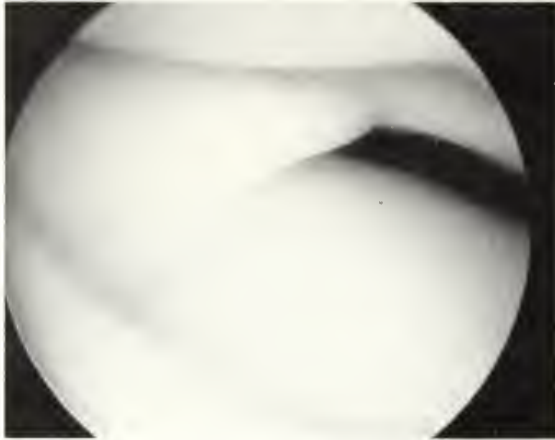


Figure 2. Laser print of discoid meniscus in this case.



Figure 3. Laser print of normal medial meniscus in this case.

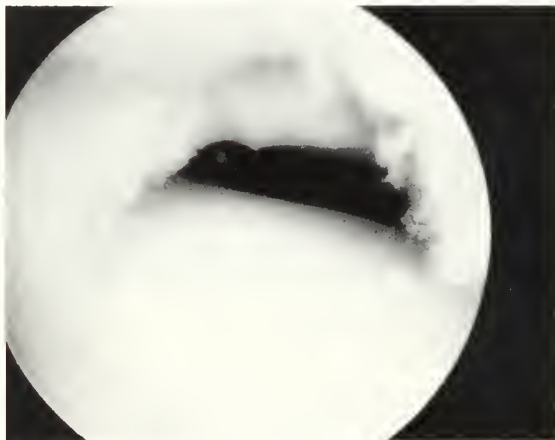


Figure 4. Laser print after partial arthroscopic meniscectomy in this case.

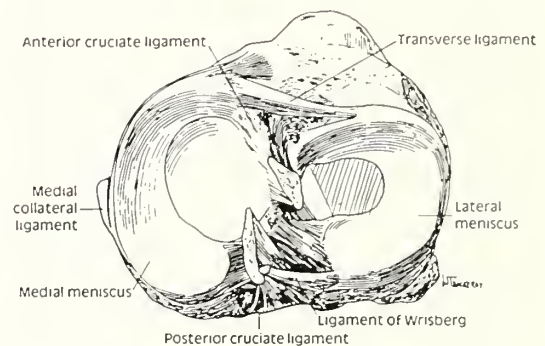


Figure 5. Schematic of normal lateral meniscus with abnormal meniscal tissue (shaded area).

to excise the central portion of the discoid meniscus. The knee was put through a range of motion and it was felt that the clunking had been eliminated.

The wound was closed, patient was awakened from general anesthesia, carried to the recovery room and discharged to follow-up in the office. The patient experienced no further clunking, had no demonstrable symptoms or limp and was overall improved from the procedure.

TECHNICAL NOTES

The tissue was so thick that the small instruments could not grasp both sides of the meniscus. The joint was so small that large

standard arthroscopy instruments would not be tolerated. In retrospect, one could have used a banana disposable arthroscopy blade to create in effect a horizontal tear through the abnormal area and then use a banana knife to create multiple vertical incisions which would allow more easy resection of the meniscus tissue.

Bellier, et al.,¹ studied 19 lateral discoid menisci in 16 children, average age 10 years. (five to 15 years.) Arthroscopic meniscectomy achieved excellent results in 18 of 19 cases. Three children had bilateral surgery. The peri-

od from first appearance of symptoms until treatment averaged six months (one month–two years).

Symptoms included snapping or locking in eight cases, locking with loss of hyperextension in 10 cases. Both symptoms were seen in five cases. There was lateral pain in 15 cases, but nonlocalized or medial (two cases). Quadriceps atrophy was constant, demonstrating the existence of anatomic pathology. Two cases of locking @ 30 flexion suggesting a tear of the meniscus.

Plain x-ray findings included 12 of 19 normal though the lateral tibial space was enlarged (lateral and inferior oblique view) in five knees. In two cases the lateral tibial eminence was blunted. Also seen is a "squared" lateral femoral condyle, and "cupped" lateral tibial plateau.²

RESULTS

There was a complete lateral discoid meniscus in 14 knees; five knees were incomplete. There were two thickenings of the intermediate segment, two posterior megahorns, one anterior megahorn. No Wrisberg ligament-type menisci were found (lacking the normal posterior tibial attachment, but with a femoral attachment by a meniscofemoral ligament). A total of 12 lateral discoid menisci were torn (eight complete and four incomplete). Eight tears were horizontal cleavage, and four were bucket handle. No medial pathology was found. There were 13 central partial menisectomies and one total menisectomy performed on 14 complete lateral discoid menisci. Five

incomplete discoid menisci were treated by partial menisectomy.

With a follow-up of three years, they had 18 of 19 cases with excellent results with the disappearance of snapping. Some snapping remained in one child, providing evidence of an incomplete menisectomy. No further treatment was given since there was no functional discomfort.

CLASSIFICATION OF DISCOID MENISCUS

- a: Complete disc-shaped type with thinner center;
- b: incomplete semilunar type with concave or convex free edge. Present in this case report;
- c: hypermobile type (Wrisberg) with no posterior tibial attachment.

FREQUENCY

In 347 consecutive scopes for meniscal lesions, Dickhaut and DeLee found 18 lateral discoid meniscal lesions (5.2%)³. A recent French study found bilaterality in 17 of 84 children (20%).⁴ □

REFERENCES

1. Bellier, Dupont, Larrain. Lateral discoid menisci in children. *Journal of Arthroscopy* Vol 5, # 1, pp. 52-56, 1989.
2. Discoid menisci. *Orthopaedic Sports Medicine*, Vol 2, pp. 1567-1568, 1989.
3. Dickhaut C, DeLee C. The discoid lateral meniscus syndrome. *J Bone Joint Surg (Am)*; 4:1068-73; 1982.
4. Mallet J, et al. Pathologie meniscale du genou de l'enfant. *Pe Chir Orthop*; 72:323-54; 1986.

MEDICAL HUMANITIES AND CLINICAL PRACTICE

NANCY DEW TAYLOR, PH. D.*

A physician, tired and overworked, finds a young couple with a sick child in his office at the end of a long day. The husband is that maddening type of patient who wants something for nothing, who waits till the last minute to seek help for the child. The physician is thoroughly exasperated and impatient, even abrupt with the family, attitudes he later regrets when, after several encounters, he comes to realize what lies behind their actions.¹

Called to the home of a child who has had a high fever for three days, another physician tries all his wiles on the girl, who absolutely refuses to open her mouth for him to look at her throat. Finally, furious at the child's refusals and fearing she may have diphtheria, he forces her mouth open. Later, recounting the visit, the physician wonders whether his actions had been an unnecessary use of force brought about by his rage and by his belief that he, the doctor, was the one who knew what was right for the patient.²

These situations come from stories by William Carlos Williams, himself a physician, and they are typical of the kinds of literary texts that are being used to encourage medical students, residents, attending physicians, and other health care workers to look at themselves and their patients in new ways. Because they spend long days attending conferences, taking care of large numbers of patients, and filling out forms, and because so many other requests are made of them, finding time to read a short story or a poem in preparation for a morning conference can occasionally be burdensome. Yet making time to do so can sometimes provide a reminder that others, too, fail to meet the varied needs

of patients, get tired and cranky, and become emotional when a patient fails to respond to treatment or dies. Literature thus serves as a reminder that the reader is not alone and enables health care workers to "recognize the power and implications of what they do."³

Since about 1972, when humanities began to be taught in medical schools,³ this new specialty area has provoked discussion and arguments in medical circles. Many medical schools—including Pennsylvania State University College of Medicine, University of Illinois at Chicago College of Medicine, University of Rochester School of Medicine and Dentistry, Northwestern, SUNY at Stony Brook School of Medicine, the Medical University of Ohio, and, in the South, East Carolina, University of South Florida, University of Tennessee, and the Institute for the Medical Humanities at the University of Texas Medical Branch in Galveston—have programs in medical humanities. As in these, medical humanities programs are sometimes housed in the medical faculty; in other places the programs can be found in the Division of Medical Ethics (Harvard), Department of Social Medicine (University of North Carolina), or the Center for Ethics and Humanities in the Life Sciences (Michigan State University College of Human Medicine).

Professors and physicians in these programs are often members of the Society for Health and Human Values. This interdisciplinary organization is devoted to research and teaching in medical humanities and biomedical ethics. Residents, clinicians, medical students, philosophers, lawyers, bioethicists, teachers of literature and medicine, dentists, faculty in art and visual studies, nurses, pastors, and others interested in the society's work make up the society's membership.

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Long before such societies and programs were formally initiated, the field of medicine recognized the contributions the humanities and fine arts can bestow. Lewis Thomas's near-perfect essays written for *The New England Journal of Medicine* spoke to "the heart of human learning about meaning, life, and death"⁴ and reflected that journal's long history of addressing humane issues through graceful writing. Great art embellishes the cover of every issue of *The Journal of the American Medical Association (JAMA)*, and inside is a weekly column called Poetry and Medicine. *Annals of Internal Medicine* also prints poems; in 1994 the journal initiated a new column called "The Internist's Reading," which the editor hoped would "amplify a physician's view of life beyond what he or she can see through a single pair of eyes."⁵ Both *JAMA* and *Annals of Internal Medicine* provide one page per issue for commentaries about the human side of medicine, called, respectively, "A Piece of My Mind" and "On Being a Doctor."

Programs in medical humanities follow, then, in an established tradition in the field of medicine, a tradition of commitment to humanistic endeavor that goes back to Hippocrates. But many practitioners question the validity of such studies as part of medical training. Recently I asked a group of physicians to read a piece by Richard Selzer, the surgeon-writer, in preparation for a conference on treating AIDS patients. Since both AIDS patients and the physicians who treat them often find themselves frustrated by the physical and ethical turmoil brought about by the disease and its treatment, I thought seeing how others handle some of these issues could provide us with new approaches, new ideas, new insights. "But you can't teach an adult to be humane or to be ethical," one of the physicians complained. I assured him I had no intention of even trying to do so, that the discussion should illuminate the complexity of both healer's and patient's roles when the two deal with this disease. The article would, I hoped, function "as a mirror, fostering inwardness and self-scrutiny."⁶

Everywhere these programs exist, teachers use the humanities, the fine arts, and cultural studies to encourage medical students, nurses, residents, faculty, allied health personnel, and administrators to examine and learn from their reactions to their work, each other, and to patients and their families. Literature plays an important role in these programs. Leaders in this field suggest that

Evaluating patients requires the skills that are exercised by the careful reader: to respect language, to adopt alien points of view, to integrate isolated phenomena (be they physical findings or metaphors) so that they suggest meaning, to organize events into a narrative that leads toward their conclusion, and to understand one story in the context of other stories by the same teller.³

The visual arts and drama can enlighten in much the same way as does reading. At the University of Illinois at Chicago School of Medicine, for instance, a group of medical students prepared a reading of a play about Alzheimer's, drove an hour and a half across the city to present it to an Alzheimer's support group, and, afterward, listened to the group's reactions. Riding back to their school, the students agreed their view of patients suffering from Alzheimer's as well as their understanding of the needs of family members were changed forever. Having had the experience of "becoming" either someone with Alzheimer's or a family member, they believed they had learned things a strictly medical lecture on Alzheimer's might never have taught them.

Scholars associated with medical humanities programs have realized that the humanities can also be a conduit for the study of medical ethics. Studying narrative allows medical personnel to put themselves in others' shoes and examine others' ethical perspectives. Recognizing different ethical perspectives usually leads to a rethinking of our own positions. Certainly understanding others' points of view can provide insight into our own actions and attitudes. A story like William Carlos Williams' "A Face of Stone,"

from which the first example at the beginning of this article is taken, provides insight into ways in which patients can aggravate physicians and ways in which physicians tend to categorize those patients. Williams' story, "The Use of Force," from which the second example was taken, asks physicians to question whether they have a right to impose treatment on all patients.

When literature and art and history are used to generate discussion, the purpose is not to impose one person's beliefs on another but to provide a safe place in which difficult questions related to modern medicine can be discussed. We encourage each other to try verbalizing beliefs we're not even sure we hold. In these meetings we can speak our minds, sometimes hesitantly, sometimes vociferously, and help each other consider which choices might be practical in the difficult medical encounters in which we find ourselves.

The discipline of medical humanities is served by several journals, among them *Literature and Medicine*, *The Journal of Medical Humanities*, and *Medical Humanities Review*. Articles about medical humanities issues are appearing regularly in other medical journals. The September 1995 issue of *Academic Medicine* takes for its theme "The Humanities and Medical Education." It contains articles on the ways history, bioethics, philosophy, literature, religion, and law can produce tough-minded thinkers who can effectively meet the challenges of medical practice. A recent article in *Annals of Internal Medicine*, written by physicians and professors from eight medical centers and universities, discusses the contributions programs in literature and medicine can make to clinical practice. The authors find the study of narratives useful in all kinds of medical environments, for they teach physicians "concrete and powerful lessons about the lives of sick people." They believe narrative knowledge helps physicians "understand patients' stories of sickness, thereby strengthening diagnostic accuracy and therapeutic effectiveness while deepening an understanding of his or her own personal

stake in medical practice."³ John O'Toole's "The Story of Ethics: Narrative as a Means for Ethical Understanding and Action" was a winner in this year's John Conley Competition (for outstanding essays on ethics) and was published in *Pulse*, the medical student section of *JAMA*. O'Toole believes that "The two most profound aspects of ethical thinking—understanding relationships and embracing different perspectives—are engendered by reading and listening to stories."⁷ In another article, published in *The Pharos*, William D. Noonan found his internship made "surprisingly and unambiguously beneficent" in a program where faculty and house staff respected each other, paid attention to their emotions, emphasized ethics, and utilized the power of the humanities to entertain and inform.⁸

In a second article, the young program in medical humanities at Greenville Memorial Hospital will be discussed. Like most hospitals, Greenville Memorial does not hire someone to lead such a program. Instead, people with a variety of backgrounds who find themselves interested in medical humanities contribute by leading or participating in conferences, grand rounds, or book discussion groups. We hope that our experiences will encourage others in South Carolina to enjoy the benefits and pleasures of such activities. □

REFERENCES

1. Williams WC. A face of stone. In: *The Doctor Stories*. Ed. Robert Coles. New York: New Directions, 78-87, 1984.
2. Williams WC. The use of force. In: *The Doctor Stories*. Ed. Robert Coles. New York: New Directions, 56-60, 1984.
3. Charon R, Banks JT, Connelly JE, et al. Literature and medicine: contributions to clinical practice. *Ann Intern Med* 122:599-606, 1995.
4. Charon R, Williams P. Introduction: the humanities and medical education. *Acad Med* 70:758-60, 1995.
5. "The Internist's Reading": literature that illuminates life [editorial]. *Ann Intern Med* 121:381, 1994.
6. Dittich L. Bleak House by Charles Dickens (Medicine and the Arts). *Acad Med* 70:36-7, 1995.
7. O'Toole J. The story of ethics: narrative as a means for ethical understanding and action. *JAMA* 273:1387, 1390, 1995.
8. Noonan WD. Must an internship be miserable? *The Pharos* 58(3):19-23, 1995.

THE MEDICAL HUMANITIES PROGRAM AT GREENVILLE MEMORIAL HOSPITAL

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At Greenville Memorial Hospital (GMH) the medical humanities have been an active part of the curriculum for residents, medical students, and some faculty and attendings since 1992 when Joseph A. McAlhany, Jr., M. D., chair of the surgery residency program, responded to an article on the liberal arts in surgery residency programs that I sent him.¹ He sent me an article about an ethics reading group in a hospital that he had in his files;² he had hoped to develop a similar program. My joining the hospital staff as a medical editor with literary credentials gave him someone to help implement it. Together we initiated a monthly seminar called "Ethics and Humanities for Surgeons." In some of these early morning conferences, poems and short stories are used to start discussions about how surgeons view themselves and how patients see them, how patients and families are affected by illness, and how their needs might differ from physicians' expectations. A poem like Sylvia Plath's "The Surgeon at 2 a.m." provokes discussion about the discoveries one makes—sometimes about the self, sometimes about life—while operating; it contains references to associates—orderlies, LPNs, night nurses—often unnoticed or taken for granted by the physician and also contains a warning that surgeons should not view themselves as "God-like fixers."³

In one meeting we discussed Dutch laws that allow physicians to participate in physician-assisted suicide. Older physicians who had lived the prime of their lives during the Second World War and its horrifying Nazi experiments had serious reservations about

physicians' participation in such actions, seeing them as a manipulation of the laws of God and as a violation of the Hippocratic Oath ("First, do no harm"). Who would make such decisions? Patients and physicians?

Some of the younger physicians also had reservations: Would we have to leave such a decision up to a Death Committee? The debate grew loud, and one attending was provoked to ask the leader, "Well, would you be willing to serve on the Death Committee?" After the leader voiced a hesitant yes, the same attending asked if anyone else present would be willing. One resident said if she found herself in a situation in which she would be vented for life, in a situation in which she could never hope to improve—"Well," she said, "just pull the plug on me—please." So, yes, I'd be on it." Only one attending thought he could participate and only under quite specific circumstances.

At the close of the exchange, the group read Sharon Olds' poem "The Promise,"⁴ in which a husband and wife repeat their vow to assist each other in dying should the need arise. One participant felt that the poem gave a different dimension to the whole discussion, bringing the issue home, making it much more personal, providing him with a new understanding of how individuals (including patients) might feel about the issue.

At another meeting, I read several passages on "cold" physicians from Reynolds Price's *A Whole New Life*, selections in which Price described being treated inhumanely by several of his physicians.⁵ Instead of leading to a discussion of why some physicians, like some people in other professions, can on occasion act inhumanely and then into a discussion of reasons why (feelings of helplessness in the face of incurable disease, for example), the

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interchange took a very different course. An attending challenged the leader: "You have made rounds with us now for several months. You know us; you know we are not like that. So why do you still choose to read us such passages that describe inhumane physicians?" After explaining I'd started with the negative and had planned to move on to the positive portraits, I answered his question honestly: "I don't know," I said. The discussion was salvaged by one of the surgeons who had read the book; he stated the last chapter was rare in books about illness. In it, Price talks about a patient's responsibilities for getting on with his life, his need to help heal himself.

A recent discussion of Price's work with the Internal Medicine group's "Not Necessarily Medicine" conference focused on completely different aspects of the book. There, a physician-leader gave a brief review of Price's case, including the negative portraits of some of his physicians. Then he emphasized the helpfulness of Price's last chapter, especially the list of three things Price suggests physicians can tell patients in similar situations. We also discussed the difficulty physicians have in dealing with patients' pain, particularly when they seem unable to relieve it. This experience with internists, so different from the one with the surgeons, serves as an excellent example of ways in which the richness of literature contributes to a variety of subjects pertinent to health care workers. I had also learned things: that readers will judge portraits of physicians for themselves, that the more positive aspects of Price's book, like those relating to the course of paraplegia, should be discussed to show how illness affects the patient far beyond his relationship with his physician.

In 1992 G. William Bates, M. D., Vice President of Medical Education & Research for the Greenville Hospital System (GHS), agreed to the instigation of the first GHS Annual Lecture in Medical Ethics and Humanities. Part of his rationale was that a complete education for those in health-related careers should include a knowledge of the

humanities and ethics as well as a knowledge of the science and practice of their medical field. Ferrol Sams, the noted Georgia physician-writer, was our first guest lecturer. Dr. Sams, a master storyteller, delighted the audience with stories about his life and work, providing a living example of how a humane physician thinks and acts. In 1993 surgeon-writer Richard Selzer was the speaker. The excerpts he read from his work prodded the audience to think about the variety and challenges of the physician-patient relationship. The next morning he led surgical grand rounds, a discussion of his story, "Whither Thou Goest,"⁶ which most of us had read beforehand. In the story, a wife whose husband's organs have been "harvested" struggles with the concept of his living on in the lives of transplant recipients. She asks the man who has received his heart to allow her to visit him and listen to her husband's heart for an hour. In our conference, Selzer pointed to individual physicians and demanded, "How do you define death?" But the fictional wife's and real physicians' views of death were not the only ones Selzer made us think about. He told us that the Japanese people's horror of the concept of harvesting organs has driven them close to perfecting a working artificial heart, an accomplishment we are far from matching.

In May of 1995 South Carolina novelist Josephine Humphreys spoke on "A Cure for What Ails Us: A Novelist's Reflections on Doctoring." Humphreys discussed ways in which writing is like the work of doctoring. In particular, she emphasized physicians' and writers' need to see, *really see*, each patient or character as an individual worthy of close attention. When she realized page four of her speech was missing, Humphreys pushed her glasses up on her head and simply talked to the audience about several passages in her novels in which medicine, either "regular" or alternative, plays a role. Like Sams and Selzer before her, she helped those in medicine see how it feels to be a patient and helped patients understand they too have responsibil-

ities in the medical encounter.

Medical humanities have also enhanced thinking about such issues through an undergraduate class and a reading group. In the winter quarter of 1995, cooperation between GHS and Furman University led to my working with Douglas MacDonald, Ph. D., a professor of philosophy who has long taught a medical ethics course and who is a member of the South Carolina Medical Association's Medical Ethics Committee. Together we co-taught a class entitled "Illness and the Individual: A Human Experience." Students in the class were pre-med as well as philosophy students, and they read a variety of texts (Table 1) that led to discussions of issues pertinent to both medical humanities and medical ethics. Since I am trained in literature and not in philosophy, the students on occasion experienced profound—and heated—disagreements between the two professors, exchanges they said they found stimulating.

When several health care personnel at GMH learned about the course and indicated interest in taking it, they encouraged me to initiate a book discussion group around texts that had been used in the class. This diverse group includes nurses, continuing medical education personnel, physicians, a statistician, an epidemiologist, the head of pastoral care at GHS, a medical librarian, a transcriptionist, husbands and wives of some of the participants, and several retired physicians. This group continues to have spirited discussions of a variety of texts (Table 2).

Our program at GMH is still young, but we are immensely excited about its possibilities and grateful that faculty and administrators as well as individual employees are supporting a variety of activities in the medical humanities. We hope that providing a place in which divergent views can be discussed will enrich the training of medical students and young physicians. We believe it has already enabled

TABLE 1. TEXTS READ IN "ILLNESS AND THE INDIVIDUAL: A HUMAN EXPERIENCE"

- Nuland, Sherwin. *How We Die*. New York: Knopf, 1994.
- Klass, Perri. *Other Women's Children*. New York: Ivy Books, 1992.
- Walker, Alice. *Possessing the Secret of Joy*. New York: Pocket Star Books, 1993.
- Kaysen, Susanna. *Girl, Interrupted*. New York: Vintage, 1994.
- Sontag, Susan. *Illness as Metaphor; AIDS as Metaphor*. New York: Anchor Books (Doubleday), 1990.
- Kushner, Tony. *Angels in America: A Gay Fantasia on National Themes; Part I: Millennium Approaches*. New York: Theatre Communications Group, 1993.
- Faulkner, William. *As I Lay Dying*. New York: Vintage International, 1990.
- Ingalls, Rachael. *Mrs. Caliban*. New York: Dell, 1992.
- Selzer, Richard. *Raising the Dead*. New York: Whittle/Viking, 1994.
- Olds, Sharon. *The Father*. New York: Knopf, 1992.
- Ferré, Rosario. *The youngest doll*. In: *The Youngest Doll*. Lincoln: University of Nebraska Press, 1991:1-6.
- Selzer, Richard. *Whither thou goest*. In: *Imagine a Woman and Other Tales*. New York: Random House, 1990:3-18.
- Anon. *It's over*, Debbie. *JAMA* 1988;259:272.
- Quill, Timothy E. *Death and dignity: a case of individualized decision making*. *New Engl J Med* 1991;324:691-694.
- Olds, Sharon. *The promise*. *The New Yorker* 11 June 1990:80.
- Selzer, Richard. *Mercy*. In: *Letters to a Young Doctor*. New York: Simon & Schuster, 1982:70-74.
- Quill, TE, Cassel, CK, Meier, DE. *Care of the hopelessly ill: proposed clinical criteria for physician-assisted suicide*. *New Engl J Med* 327:1380-1384, 1992.
- Brody, H. *Assisted death—a compassionate response to a medical failure*. *New Engl J Med* 327:1384-1388, 1992.
- Selzer, Richard. *Brute*. In: *Letters to a Young Doctor*. New York: Simon & Schuster, 1982:59-63.
- Williams, William Carlos. *A face of stone*. In: *The Doctor Stories*. Ed. Robert Coles. New York: New Directions, 1984:78-87.
- King, Nancy M.P., Stanford, Ann Folwell. *Patient stories, doctor stories, and true stories: a cautionary reading*. *Lit Med* 1992;11:185-199.
- Faulkner, William. *Pantaloon in black*. In: *Go Down, Moses*. New York: Vintage, 1973:135-159.
- Stone, John. *An infected heart*. In: *In the Country of Hearts: Journeys in the Art of Medicine*. New York: Delta, 1992:75-80.

TABLE 2. TEXTS READ IN GREENVILLE MEMORIAL HOSPITAL
BOOK DISCUSSION GROUP

Spring of 1995

- Humphreys, Josephine. *Dreams of Sleep*. New York: Penguin, 1984.
- Klass, Perri. *Other Women's Children*. New York: Ivy Books, 1992.
- Price, Reynolds. *A Whole New Life: An Illness and a Healing*. New York: Atheneum, 1994.
- Selzer, Richard. *Raising the Dead*. New York: Whittle/Viking, 1994.
- Thomas, Lewis. *The Youngest Science*. New York: Penguin, 1995.
- Walker, Alice. *Possessing the Secret of Joy*. New York: Pocket Star Books, 1993.

Fall of 1995

- Doerr, Harriet. *Stones for Ibarra*. New York: Penguin, 1985.
- Heymann, Jody. *Equal Partners: A Physician's Call for a New Spirit in Medicine*. New York: Little, Brown, 1995.
- Williams, William Carlos. *The Doctor Stories*. Ed. Robert Coles. New York: New Directions, 1984.
- Winterson, Jeanette. *Written on the Body*. New York: Vintage, 1993.

attending physicians and others of us involved in health care to enhance our perception of patients' needs and that it has led to the provision of even better care. □

REFERENCES

1. McGreevy JM. Liberal arts in the surgery residency. *Acad Med* 67(1):32-3, 1992.
2. Radwany SM, Adelson BH. The use of literary classics in teaching medical ethics to physicians. *JAMA* 257:1629-31, 1987.
3. Plath S. The surgeon at 2 a.m. In: *The Collected Poems*. Ed. Ted Hughes. New York: Harper & Row, 1981.
4. Olds S. The promise. *The New Yorker* 11 June 1990:80.
5. Price R. *A Whole New Life: An Illness and a Healing*. New York: Atheneum, 1994.
6. Selzer R. Whither thou goest. In: *Imagine a Woman and Other Tales*. New York: Random House, 1990:3-18.

Editorials

MANAGED CARING (!) (?)

Is "managed care" an oxymoron? Consider the following scenario related by a physician from a state where this form of physician reimbursement is now the norm:

A 27-year-old primigravida in her first trimester was told that her managed care contract required that she obtain a new obstetrician whose office was on the other side of town. At her second visit, she was told that an ultrasound examination was indicated and that the managed care contract would reimburse her only if she went to a designated radiologist, located an hour's drive away. She elected to pay for the ultrasound out-of-pocket at an office across the street from her new obstetrician. Six weeks later, by which time she was well into her second trimester, she was told by the obstetrician's office assistant that the ultrasound examination showed a lethal birth defect and that abortion was therefore indicated.

The patient's father, who happened to be a prominent physician, called the chief executive officer of the managed care insurance company to complain about the way his daughter had been treated. The last straw, he said, was that the company's designated obstetrician did not break the bad news himself. The insurance executive expressed his sympathy, but explained that to require the obstetrician to place the telephone call himself would have been cost-ineffective.

The patient was managed (well, more or less) but it seems that care was forgotten in the name of financial self-interest.

Caring, like Lewis Carroll's snark, can be an elusive concept and it sometimes seems that those physicians who talk the most about it are the same ones who seldom if ever take night call. However, certain components of

caring are reasonably clear. The physician must be present for the patient. The physician must acknowledge the patient, respect the patient, listen to the patient, and be willing to engage the patient in dialogue.¹ All of this takes a great deal of time.

It is not my purpose to rail against managed care as a way to reduce costs and restore emphasis on primary care. Whether managed care will be even a partial answer to American's perceived health care crisis will take years to determine. As individual physicians, there is relatively little that we can do about the structuring of health care financing. But collectively, we should be extremely concerned about the impact of managed care on our professionalism. There is a growing suspicion that the large insurance companies seek to treat medical services like any other product. Today's lexicon contains many frightening terms: capitated lives, product lines, economic credentialing, cost-benefit ratios, risk-sharing, to name but a few. Medicine is being treated as a technical service in which physicians are prized for their competence but not necessarily for their caring.

Let us not forget the classic statement on caring by Dr. Francis Weld Peabody who, dying of cancer, lectured to Harvard medical students on "The Care of the Patient." Peabody gained immortality with these words:

The good physician knows his patients through and through, and his knowledge is bought dearly. Time, sympathy, and understanding must be lavishly dispensed, but the reward is to be found in that personal bond which forms the greatest satisfaction in the practice of medicine. One of the essential qualities of the clinician is interest in

humanity, for the secret of the care of the patient is in caring for the patient.²

Can one be such a good physician in a highly structured environment that places a premium on time efficiency? Probably not, at least not for long. Managed care has already brought a new syndrome among physicians: "hassle hypertension."³ Physicians' disability insurance claims increasingly reflect nervous and mental disorders attributable to the stress of practice. And managed care threatens the fabric of academic medicine.⁴ It seems likely that no physician, practice, or institution is entirely safe from the swath that is already being cut through our health care delivery system.

Is there any basis for optimism? The answer is yes, and one need look no further than this issue of *The Journal*. Dr. Nancy Dew Taylor's two articles on the humanities in the practice of medicine reinforce the notion that the good physician should be a broadly-educated person sensitive to all of the issues raised by our common human predicament. For nearly two millennia, we have embraced the essential role of *humanitas*—compassion—in medical practice.⁵ And Dr. John Black's remembrances of the qualities modeled and taught by his father,

the late Dr. Swift C. Black of Dillon, remind us of our good fortune to have been associated with such role models in South Carolina medicine (Table). But we can be optimistic only to the extent that we take a stand. We must be willing to defend our heritage as a caring profession, even if taking such a stand may be detrimental to our own financial self-interests in the short run. We must recognize that taking such a stand, both individually and through our organizations, may be our only chance for preserving medicine as we have been fortunate to know it.

—CSB

REFERENCES

1. Adson MA: An endangered ethic—the capacity for caring. *Mayo Clin Proc* 70: 495-500, 1995.
2. Peabody FW: The care of the patient. *JAMA* 88: 877-882, 1927.
3. Phillips WR: Hassle hypertension: a risk of managed care (letter). *JAMA* 274: 795-796, 1995.
4. Kralewski JE, Hart G, Perlmutter C, et al.: Can academic medical centers compete in a managed care system? *Academic Medicine* 70: 867-872, 1995.
5. Pellegrino ED, Pellegrino AA: Humanism and ethics in Roman medicine: translation and commentary on a text by Scribonius Largus. In Barondess, JA, Roland CG, eds.: *The Persisting Osler—II* (Malabar, FL: Krieger, 1995), 21-34.

TABLE: COMPONENTS OF CARING TAUGHT AND MODELED BY THE LATE DR. SWIFT C. BLACK OF DILLON, SOUTH CAROLINA*

1. Remember that the human body can do a lot of healing on its own.
2. Remember that most of the time the patient just wants a friend to trust his secrets ... his needs...his fears.
3. Remember the patients who cannot afford to pay.
4. Take time to listen. The patient will tell you what is wrong.
5. Never be afraid to acknowledge that you don't know something.
6. Never forget the healing power of faith in God.
7. Don't be arrogant.
8. Tell the patient what is really wrong with him in plain language.
9. Remember that nurses and other medical personnel are your friends and teammates.
10. Don't forget to touch the patient.

*Compiled by Dr. John G. Black and presented more fully in a letter-to-the-editor in this issue.



Continuing Medical Education

First Quarter
1996
Calendar

James L. Haynes, M. D., Chairman

Published by the SCMA Committee on Continuing Medical Education
Post Office Box 11188, Columbia, SC 29211

Note: CME activities in neighboring states are listed when space permits.

JANUARY

Wednesday January 3, 1996
Columbia, SC, James F. Byrnes Center for Geriatric
Medicine, Education and Research
Developing a Research Program

SPONSOR: Byrnes Center
CONTACT: JoAnn Watts, (803) 734-0812
FACULTY: Germaine Odenheimer, MD
CME CREDITS: 1 Hour, AMA Category 1

Wednesday January 10, 1996
Columbia, SC, James F. Byrnes Center for Geriatric
Medicine, Education and Research
Preventive Geriatrics

SPONSOR: Byrnes Center
CONTACT: JoAnn Watts, (803) 734-0812
FACULTY: Sue Scally, PhD
CME CREDITS: 1 Hour, AMA Category 1

Monday—Friday January 22–26, 1996
Columbia, SC, Richland Memorial CCTR 6th Floor
Classroom

Primary Training in Hyperbaric Medicine
SPONSOR: USC School of Medicine
DESCRIPTION: A comprehensive introduction to the
role of hyperbaric oxygen therapy in current medical
practice.

TYPE OF AUDIENCE: Physicians, respiratory thera-
pists, technologists, and nurses involved in hyperbaric
oxygen therapy.
CONTACT: Susan Pearson, (803) 434-4211
FEE: \$650, \$500, \$375
FACULTY: Dick Clarke and Robert L. Bartlett, MD
CME CREDITS: 40 Hours, AMA Category 1

Wednesday January 24, 1996
Columbia, SC, James F. Byrnes Center for Geriatric
Medicine, Education and Research
Safety in the Elderly
SPONSOR: Byrnes Center

CONTACT: JoAnn Watts, (803) 734-0812
FACULTY: Sally Weinrich, PhD
CME CREDITS: 1 Hour, AMA Category 1

FEBRUARY

Wednesday February 7, 1996
Columbia, SC, James F. Byrnes Center for Geriatric
Medicine, Education and Research
Research Conference

SPONSOR: Byrnes Center
CONTACT: JoAnn Watts, (803) 734-0812
FACULTY: Germaine Odenheimer, MD
CME CREDITS: 1 Hour, AMA Category 1

Saturday February 10, 1996
Charleston, SC, MUSC
Alcoholism and Substance Abuse Treatment: An Update
SPONSOR: Medical University of SC
CONTACT: Karen Stewart, (803) 792-0068
PROGRAM FEE: TBA
FACULTY: Guest Faculty and Local Faculty
CME CREDITS: TBA Hours, AMA Category 1

Wednesday February 14, 1996
Columbia, SC, James F. Byrnes Center for Geriatric
Medicine, Education and Research
Treatment of Bipolar Disease
SPONSOR: Byrnes Center
CONTACT: JoAnn Watts, (803) 734-0812
FACULTY: Robert N. Milling, MD
CME CREDITS: 1 Hour, AMA Category 1

Saturday February 17, 1996
Greenwood, SC, Nisbet Education Center, Self
Memorial Hospital
6th Annual Update in Addiction Medicine
SPONSOR: Recovery Center at Self Memorial Hospital
TYPE OF AUDIENCE: Practicing physicians
BRIEF DESCRIPTION: Update in current addiction top-
ics, including identification, intervention, and pharma-

cologic management issues.

TYPE OF AUDIENCE: Primary care physicians

CONTACT: Randy Cain, MD, (864) 227-5000

PROGRAM FEE: \$50

FACULTY: Jim Finch, MD; Ted Clark, MD; Hunter

Woodall, MD; and Robert Malcolm, MD

CME CREDIT: 5.75 Hours, AMA Category 1 and 5.75

AAFP Prescribed Hours

Monday—Saturday February 19-24, 1996

Augusta, GA

31st Annual Primary Care & Family Practice Symposium

SPONSOR: School of Medicine, Medical College of GA

CONTACT: Katrinka Akeson, (706) 721-3967 or 1-800-

221-6437

CME CREDITS: 52 Hours, AMA Category 1

Friday February 23, 1996

Charleston, SC, MUSC

Federal & State Controlled Substance Acts Conference

SPONSOR: Medical University of SC

TYPE OF AUDIENCE: Practicing physicians

CONTACT: Pam Missroon, (803) 792-4071

PROGRAM FEE: TBA

FACULTY: Guest Faculty and Local Faculty

CME CREDITS: TBA Hours, AMA Category 1

Friday February 24, 1996

Columbia, SC, Embassy Suites

Liver Disease & Transplant Symposium

SPONSOR: Medical University of SC

TYPE OF AUDIENCE: Practicing physicians

CONTACT: Pam Missroon, (803) 792-4071

PROGRAM FEE: TBA

FACULTY: Guest Faculty and Local Faculty

CME CREDITS: TBA Hours, AMA Category 1

Monday—Friday Feb. 26-March 1, 1996

Columbia, SC, Richland Memorial CCTR 6th Floor Classroom

Primary Training in Hyperbaric Medicine

SPONSOR: USC School of Medicine

DESCRIPTION: A comprehensive introduction to the role of hyperbaric oxygen therapy in current medical practice.

TYPE OF AUDIENCE: Physicians, respiratory therapists, technologists, and nurses involved in hyperbaric oxygen therapy.

CONTACT: Susan Pearson, (803) 434-4211

FEE: \$650, \$500, \$375

FACULTY: Dick Clarke and Robert L. Bartlett, MD

CME CREDITS: 40 Hours, AMA Category 1

Wednesday February 28, 1996

Columbia, SC, James F. Byrnes Center for Geriatric

Medicine, Education and Research

Articles That Utilize Lifetable Analyses

SPONSOR: Byrnes Center

CONTACT: JoAnn Watts, (803) 734-0812

FACULTY: Carlton A. Hornung, PhD, MPH

CME CREDITS: 1 Hour, AMA Category 1

MARCH

Friday—Saturday March 1-2, 1996

Augusta, GA

Flexible Fiberoptic Sigmoidoscopy

SPONSOR: School of Medicine, Medical College of GA

CONTACT: Katrinka Akeson, (706) 721-3967 or 1-800-

221-6437

CME CREDITS: 14 Hours, AMA Category 1

Saturday—Sunday March 2-3, 1996

New Orleans, LA, The Royal Sonesta Hotel

Violence: Implications for Clinical Practice

SPONSOR: American Psychiatric Association

CONTACT: Maria Gorrick, (202) 682-6145

PROGRAM FEE: \$225 APA member, \$275 Non-member physician, \$250 Non-physician professionals, \$150 Residents and Fellows

CME CREDITS: 14 Hours, AMA Category 1

Sunday—Tuesday March 3-5, 1996

Charleston, SC, Omni Hotel

Sixth Charleston Pulmonary & Critical Care Symposium

SPONSOR: Medical University of SC

TYPE OF AUDIENCE: Pulmonologists and internists

CONTACT: Pat Missroon, (803) 792-4071

PROGRAM FEE: TBA

FACULTY: Guest faculty and local faculty

CME CREDITS: TBA Hour, AMA Category 1

Wednesday March 6, 1996

Columbia, SC, James F. Byrnes Center for Geriatric Medicine, Education and Research

Research Conference

SPONSOR: Byrnes Center

CONTACT: JoAnn Watts, (803) 734-0812

FACULTY: Germaine Odenheimer, MD

CME CREDITS: 1 Hour, AMA Category 1

Thursday March 7, 1996

Columbia, SC, Richland Memorial Hospital

Hospital Ethics

SPONSOR: USC School of Medicine

DESCRIPTION: Ethics Committee educational program for RMH Ethics Committee and a few invited guests.

TYPE OF AUDIENCE: Members hospital Ethics Committee

CONTACT: Susan Pearson, (803) 434-4211

FACULTY: Steinert Spicker, MD and George Agich, M

CME CREDITS: 6 Hours, AMA Category 1

Wednesday March 13, 1996
Columbia, SC, James F. Byrnes Center for Geriatric Medicine, Education and Research
Grand Rounds
SPONSOR: Byrnes Center
CONTACT: JoAnn Watts, (803) 734-0812
FACULTY: Lynn Hackett, MD
CME CREDITS: 1 Hour, AMA Category 1

Thursday—Friday March 14-15, 1996
Charleston, SC, College of Charleston Conference Center
Annual GI Conference
SPONSOR: Medical University of SC
TYPE OF AUDIENCE: Gastroenterologists and internists
CONTACT: Rita Oden, (803) 792-6865
PROGRAM FEE: TBA
FACULTY: Guest faculty and local faculty
CME CREDITS: TBA Hour, AMA Category 1

Thursday—Saturday March 14-16, 1996
Columbia, SC, Richland Memorial Hospital, Mitchell Auditorium
Advanced Training in Hyperbaric Medicine
SPONSOR: USC School of Medicine
BRIEF DESCRIPTION: Three-day didactic program on thermal burns, brown recluse bites, hyperbaric oxygen and radiotherapy, skin flaps/grafts, hyperbaric medicine in surgical infections.
TYPE OF AUDIENCE: Consulting hyperbaric physicians
CONTACT: Susan Pearson, (803) 434-4211
PROGRAM FEE: \$495/395
FACULTY: Dick Clark, Robert L. Bartlett, MD and others
CME CREDITS: 18.5 Hours, AMA Category 1

Thursday—Saturday March 14-16, 1996
Charleston, SC, Charleston Place
Eighth Charleston Symposium on Congenital Heart Disease
SPONSOR: American Academy of Cardiology
CONTACT: Registration Secretary, 1-800-257-4739
CME CREDITS: 14.5 Hours, AMA Category 1

Monday—Tuesday March 17-19, 1996
Charleston, SC, Mills House Hotel
Radiology for the Primary Care Physician
SPONSOR: Medical University of SC
TYPE OF AUDIENCE: Family physicians and internists
CONTACT: Clydie deBrux, (803) 792-4267
PROGRAM FEE: TBA
FACULTY: Guest faculty and local faculty
CME CREDITS: TBA Hour, AMA Category 1

Thursday—Sunday March 21-24, 1996
Augusta, GA
Organ & Tissue Procurement & Transplantation: An Advanced Course
SPONSOR: School of Medicine, Medical College of GA
CONTACT: Katrinka Akesson, (706) 721-3967 or 1-800-221-6437
CME CREDITS: 14 Hours, AMA Category 1

Friday—Saturday March 22-23, 1996
Augusta, GA
Ophthalmology Resident--Alumni
SPONSOR: School of Medicine, Medical College of GA
CONTACT: Katrinka Akesson, (706) 721-3967 or 1-800-221-6437
CME CREDITS: 10 Hours, AMA Category 1

Wednesday March 27, 1996
Columbia, SC, James F. Byrnes Center for Geriatric Medicine, Education and Research
Feeding & Instage Dementia
SPONSOR: Byrnes Center
CONTACT: JoAnn Watts, (803) 734-0812
FACULTY: Kathy Hogan, NP; Eula Boyleston; and C. David Johnson, MD
CME CREDITS: 1 Hour, AMA Category 1

Thursday—Friday March 28-29, 1996
Charleston, SC, Francis Marion Hotel
Bridge Run Sports Medicine Conference
SPONSOR: Medical University of SC
TYPE OF AUDIENCE: Practicing physicians, internists, and orthopedic surgeons
CONTACT: Pam Missroon, (803) 792-4071
PROGRAM FEE: TBA
FACULTY: Guest Faculty and Local Faculty
CME CREDITS: TBA Hours, AMA Category 1

Thursday—Friday March 28-29, 1996
Charleston, SC, Francis Marion Hotel
Ophthalmology Update
SPONSOR: Medical University of SC
TYPE OF AUDIENCE: Practicing physicians, internists, and orthopedic surgeons
CONTACT: Maddie Manuel, (803) 792-2760
PROGRAM FEE: TBA
FACULTY: Guest Faculty and Local Faculty
CME CREDITS: TBA Hours, AMA Category 1

Friday—Saturday March 29-30 1996
Columbia, SC, Embassy Suites
18th Annual Carolina Cup Pediatric Symposium
SPONSOR: USC School of Medicine
BRIEF DESCRIPTION: Annual symposium to provide

attendees with recent clinical advances in care of pediatric patients.

TYPE OF AUDIENCE: Pediatricians and family practitioners

CONTACT: Susan Pearson, (803) 434-4211

PROGRAM FEE: \$135

FACULTY: USCSC and invited faculty

CME CREDITS: 8 Hours, AMA Category 1

Friday—Saturday March 29-30 1996

Columbia, SC, Embassy Suites

Primary Care Forum

SPONSOR: USC School of Medicine

BRIEF DESCRIPTION: Annual symposium targeted to primary care physicians.

TYPE OF AUDIENCE: Pediatricians and family practitioners

tioners

CONTACT: Susan Pearson, (803) 434-4211

PROGRAM FEE: TBA

FACULTY: USCSM/RMH staff and invited faculty

CME CREDITS: 8 Hours, AMA Category 1

Sunday—Wednesday

March 31-April 1, 1996

Charleston, SC, Omni Hotel

Azaleas, Dogwoods & Obstetrical Controversies

SPONSOR: Medical University of SC

TYPE OF AUDIENCE: Obstetricians and gynecologists

CONTACT: Odessa Ussery, (803) 792-4071

PROGRAM FEE: TBA

FACULTY: Guest faculty and local faculty

CME CREDITS: TBA Hour, AMA Category 1

CME COMMITTEE

James L. Haynes, MD, CHAIRMAN, 2 Richland Medical Park, Suite 402, Columbia 29203

Stoney A. Abercrombie, MD, VICE CHAIRMAN, 160 Academy Avenue, Greenwood 29646

Marion C. Anderson, MD, MUSC, 171 Ashley Avenue, Charleston 29425

Charles M. Collins, MD, 204 E. Cheves Street, Florence 29506

Sami B. Elhassani, MD, 100 Willow Lane, Spartanburg 29307-1343

Roger A. Gaddy, MD, P.O. Box 29, Winnsboro 29180

David H. Lamb, MD, 169-C Medical Circle, West Columbia 29169

William Mills, MD, 1400 Highway 544, Conway 29526

Terry A. Payton, MD, 105 Wexhurst Road, Columbia 29212

Lucius Pressley, Jr., MD, P.O. Box 202, Columbia 29202

William M. Simpson, Jr., MD, 171 Ashley Avenue, Charleston 29425

Spence Taylor, MD, GHS, 701 Grove Road, Greenville 29605

Letters to the Editor

The following memories were shared at the funeral of Swift C. Black, M. D., on October 2, 1995 by his son, John G. Black, M. D., of Lexington, SC:

We are here today to honor and remember my father. We all have special memories of him that we will cherish in future years. I was lucky to have him as a role model as I grew up. He imprinted qualities of character that run deep into my fiber...things like honesty, patience, humility, love for one's fellow man, pride in a job well done, and a sense of charity or giving to others.

He taught me many practical or handy bits of knowledge that I can sum up with one statement: Don't give up trying to fix something until you have used a coat hanger and a pair of pliers.

But, I was also fortunate to have a teacher or mentor who taught me how to be a better physician. He didn't waste time teaching me the book facts—he counted on me to learn this information. What he did was to polish a rough stone. See if these comments sound like Dr. Swift Black because these concepts carried over into his non-medical life as well. Here are just a few:

1. Remember that the human body can do a lot of healing on its own. Don't get in the way too much as a physician. And don't prescribe too many medicines.
2. Most of the time, a patient just wants a friend to trust with his secrets...his needs...his fears. Don't get into so much of a hurry that you forget to build a relationship.
3. Remember the patients who can't afford to pay. They may be there in their best Sunday clothes, but they need a little help...and they need to keep their pride.
4. If you just listen, the patient will tell you what is wrong with him. Take time to listen.
5. Never be afraid that you don't know something. Feel free to look it up or to

refer the patient to someone who does know the answer.

6. Never forget the healing power of faith in God. The physician just has some of the knowledge and he needs the higher power of God and the patient's faith in God to succeed.
7. Don't be arrogant. It is easy to start feeling that you are more powerful than you really are.
8. Tell the patient what is really wrong with him and don't use those fancy doctor words. Many patients are afraid to talk openly in a doctor's office because they might look dumb. Take the time to make sure that the patient understands his illness.
9. Nurses and other medical personnel are your friends and teammates—not someone to yell at or to blame when things don't go just right.

And, he reminded me of this one two weeks ago while he himself was a patient at Lexington Medical Center.

10. Don't forget to touch the patient. It is so important to communicate through touch. The patient needs that physical touch by the physician.

If any of you were fortunate to pick up some of Dad's practical knowledge, then put it to use. And, remember where you learned it. And, pass it on to others. Dad has left this earth, but his goodness and practicality live on in us all.

I recently became aware of this verse of scripture from Paul's letters. Paul understood the influence of one's thoughts on one's left, in that what a person allows to occupy his mind will sooner or later determine his speech and his action. This reading is from Philippians 4:8-9. See if this reminds you of

Dad...

"Finally, brothers, whatever is true, whatever is noble, whatever is right, whatever is pure, whatever is lovely, whatever is admirable—if anything is excellent or praiseworthy—think about such things. Whatever

you have learned or received or heard from me, or seen in me—put it into practice. And the God of peace will be with you."

John G. Black, M. D.

134 Ease Medical Lane

West Columbia, SC 29169

PHYSICIAN RECOGNITION AWARDS

The following SCMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned.

Larry D. Bartel, M. D.

Lisa H. Bryant, M. D.

David R. Chapman, M. D.

Steven M. Cremer, M. D.

Daniel E. DeCamps, M. D.

Nguyen N. Giep, M. D.

Malvern C. Holland, M. D.

Ralph E. Lattimore, M. D.

Robert E. Mitchell, M. D.

Jennings G. Pressly, M. D.

Thomas M. Price, M. D.

Eugene F. Smith, M. D.

Richard E. Townsend, M. D.

Leo L. Walker, M. D.

Allan M. Weldon, M. D.

Samuel E. Wood, M. D.

On the Cover:

WILHELM CONRAD ROENTGEN 1845–1923

On December 28, 1895, there appeared in the journal of the Wurtzburg Physical Medical Society a paper that would forever change the course of medical history. Dr. Roentgen, a professor of physics at the University of Wurtzburg, had discovered a previously unknown ray that could penetrate human flesh! Because of the relative ease in producing these rays, the discovery spread rapidly, not only in the scientific community, but among entrepreneurs as well. Roentgen refused to patent any part of his discovery and spurned all commercial offers. In fact, after a few months of working with the rays, he focused his attention on other phenomena of physics.

Meanwhile, the world was agog. Studios were set up offering "bone portraits" which some proper ladies avoided for modesty's sake. Sideshows and magicians used x-rays to guess what was in women's purses. Lead underwear was designed in case one was caught unawares by "those naughty Roentgen Rays." And many, including Thomas Edison, looked forward to the day when each home

would have its own x-ray so that medical diagnoses could be made without a trip to the doctor.

By the year following their discovery, x-rays were being used to irradiate skin cancers with remarkable results. They were tried briefly to diagnose pregnancy, but this was abandoned because of the poor quality of the "picture of the baby." The most immediate usefulness was in the fields of orthopedics and gunshot wounds, eliminating the painful manipulations and probings of earlier days.

The first known medical use in South Carolina was on April 2, 1897, when a patient suffering from a bullet wound was taken to Porter Military Academy to the lab of Charles J. Colcock, Professor of Physics, where the recently acquired x-ray equipment made the bullet clearly visible in the chest.

Dr. Roentgen died on February 10, 1923. "The whole German nation mourns at the bier of its great son."

Betty Newsom
The Waring Historical Library



Alliance Page

SCMAA PHYSICIANS' FAMILY SUPPORT COMMITTEE

Because physicians are dedicated to helping others, they are often reluctant to ask for help themselves, or even admit to themselves that they could use some help from others. Doctors have been made to feel that they must have all the answers and be able to solve all problems. Frequently, this lopsided thinking spills over on to the "medical family" as well. Yet, helping cuts both ways! All people and all families experience difficulties from time to time. In fact, working in the medical profession involves hazards and pitfalls in addition to the usual array of problems experienced by other families.

Keenly aware that medical families have some unique problems, and that physicians' families are often reluctant to ask for help, the Physicians' Family Support Committee, a special committee of the SCMA Alliance, stands ready to provide peer support in a comfortable, confidential and easily accessible way. One confidential phone call to Cathy Boland at SCMA Headquarters (1-800-327-1021, ext. 232) can put any SC physician or his/her spouse in touch with someone who can help or someone who can just listen. There is no reason for anyone to struggle with a problem alone.

The Physicians' Family Support Committee offers direct contact with SCMA members and their families by sending notes of congratulation for such occasions as passing "the boards," birthdays and new arrivals, or notes of sympathy and support in cases of illness, accident or loss of a loved one. If you know of a person or family needing a message of this sort, please contact Derinda Connor at 132 Governors Creek Drive, Orangeburg, 29115 (803-531-8500).

Another major focus of the committee is providing support for the families of impaired physicians. The impairment may be due to alcoholism, drug addiction, mental illness, aging and senility, abuse, grief, long-term illness, a malpractice suit or marital/family problems.

The widespread, but often "hidden" or unspoken, problem of chemical dependence can seem insurmountable to an individual doctor or his/her family. It becomes a very manageable thing with help from the SCMA Physicians Advocacy and Assistance Committee. The PAAC can advise and assist the physician in matters related to treatment, licensure, malpractice, finances, legal issues, job and practice, and all aspects of recovery. The alliance "sister" group, the Physicians' Family Support Committee, works very closely with the PAAC to provide the needed support and assistance for the impaired physician's family.

The program is coordinated by Kaye Borgstedt and Barbara Clark. Speakers are available for alliance or medical society meetings to share personal experiences, especially the positive aspects of recovery and the opportunities for personal growth.

For additional information regarding the SCMAA Physicians' Family Support Committee, please contact Cathy Boland at the SCMA at 1-800-327-1021, ext. 232, Barbara Clark in Clemson at 1-803-654-5680, or Kaye Borgstedt at 1-803-534-2585. Sometimes just a brief inquiry can be a helpful first step.

Derinda Connor, Chairperson

Kaye Borgstedt and Barbara Clark, Co-Chairs

Gray Matter

*"Matters of Interest
to South Carolina
Physicians."*

Thornton & Thorne give the medical community something to think about this month.

WHY DO YOU GO TO WORK?

Why do you get up and go to work each morning? Is it because you just love what you're doing or because you need at least *some* of the income to support yourself and your family?

If you need at least *some* of the income, *how much of it do you need?* Would you need less if you became disabled? Our experience shows that while *income decreases* during a disability, *outgo increases*.

If you need at least *some* of your income, prudent risk management dictates that you *insure that income*. If you want to insure it with a policy that has a *guaranteed* premium, you may only have a short time to do so.

Which contract would you rather have with the insurance company? One that

says "*we guarantee that this premium will not change prior to age 65*" or one that says "*this is your current premium but we reserve the right to increase it.*"

We are witnessing the demise of the individual *non-cancelable* disability policy. This is the policy form that guarantees that the company can never change the premium. It is also the policy form with the best definitions.

Only a few companies issue non-cancelable policies today; soon there will be even fewer. The products that will replace the non-cancelable policies are starting to appear. We have examined them and can state unequivocally that they are not as good!

Actual claims experience on disability policies has been much worse than priced for. Companies are not able to adjust premiums on *non-cancelable* policies but in the future will be able to do so on new policies with adjustable premiums. You can review the increase on your health insurance premiums to get a feel for what will happen to disability premiums.

For the time being, SCMA Members are eligible for a 25% premium discount on

a *non-cancelable* policy with the highest quality definitions. Quite frankly, we don't know how long this product will be available but think it's very limited. If you would like to receive information about this product, please return the enclosed response. ***Time is of the essence.***

Views expressed herein are those of the authors only and in no way represent the SCMA. We do not give tax advice. Only your attorney and accountant are qualified to do so.

MAIL RESPONSE TO: **Carolina Physicians Advisory Service**
Post Office Box 688
Columbia, SC 29202-0688

Name _____ Specialty _____

Address _____ City _____ Zip _____

Have you used tobacco in the past 12 months? YES _____ NO _____

DOB _____ SEX _____ MONTHLY BENEFIT DESIRED \$ _____

Views expressed herein are those of the authors only and in no way represent the SCMA. We do not give tax advice. Only your attorney and accountant are qualified to do so.



Carolina Physicians Advisory Service

Billy M. Thornton
John T. Thorne

Serving the members of the South Carolina Medical Community.
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